TWIN CITIES ORTHOPEDICS

Internal Use Only | Account #_____
Pickup Instructons_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:		
	DOB: / /	PREVIOUS NAME(S):	
2. RELEASE MY RECORDS FROM	FACILITY NAME:		
	DR. NAME:		
3. SEND MY RECORDS TO	NAME:	ATTN TO:	
	ADDRESS:		
	CITY:	STATE:	ZIP:
	PHONE:	FAX (For Continuing Care ONLY):	
	EMAIL: (Only if you want records sent via encrypted email)		
4. TYPES OF RECORDS	BODY PART:		
	DATE(S) OF SERVICE:		
	Do you need imaging studies? ☐ Yes ☐ No ☐ Images AND Records Below (All images will be sent via email or pushed electronically to the outside entity listed) ☐ Office Notes ☐ Hospital Reports ☐ Radiology Reports ☐ Therapy (Occupational or Physical) ☐ Lab Reports ☐ Sports Physical		
5. VERBAL DISCLOSURE	For verbal disclosure, check here:_____		
	"Verbal disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section:		
6. REASON FOR REQUEST	☐ Personal Use ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care		
7. RETURN COMPLETED FORMS TO:	**MAIL TO:** Treating Clinic Location (see details at TCOmn.com/Locations)	**EMAIL TO:** recordsrelease@TCOmn.com **FAX TO:** 952-456-7020 **DROP OFF:** Treating Clinic Location	
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicted above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form. SIGNATURE:_____DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.		

Electronic or Typed Signatures cannot be accepted