

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

1. Patient	Name	DOB
	Previous Name(s)	Primary Phone
	Address	Additional Phone
	City	State Zip

2. Release my records from	Name	Dr. Name
	Address	
	City	State Zip

3. Release my records to:	Name	Dr. Name
	Address	Phone
	City	State Zip
	For Verbal Disclosure, check here _____ Verbal Disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section.	

4. Requests will not be processed if this section is not complete: <i>Requests may take up to 2 weeks to be processed.</i>	<input type="checkbox"/> Office Notes <input type="checkbox"/> Radiology/MRI Images on CD <input type="checkbox"/> Lab reports	<input type="checkbox"/> Radiology/MRI reports <input type="checkbox"/> Hospital Records <input type="checkbox"/> Therapy (Physical and Occupational)	To release records for only specific dates or body parts, please complete this section: <input type="checkbox"/> Body Part only _____ <input type="checkbox"/> Date(s) of service _____
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5. Reason For Request	<input type="checkbox"/> Personal Use <input type="checkbox"/> Disability	<input type="checkbox"/> Insurance <input type="checkbox"/> Legal	<input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Continuing Care
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6. Return completed form to: Twin Cities Orthopedics Attn: ROI Dept. 5803 Neal Ave. N. Oak Parks Heights, MN 55086 763-504-2729.	Or faxed to: 952-456-7020 Or drop off at any TCO Location	Records will be mailed to the person(s) or facilities identified in section 3 unless other arrangements for delivery are made at time of form submission.
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7. I understand that by signing below	<ul style="list-style-type: none"> 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 indicated in sections 2 and 3 of this form. 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. <p> Signature of Patient/Guardian _____ Date _____ Print Name _____ </p> <p><small>*If form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.</small></p>
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