VIRGINIA ORTHOPAEDIC CENTER, P.C.

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BONNY WAGNER, OTR, CHT

REQUEST TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DATE: _____

SOCIAL SECURITY # _____ DOB _____

PLEASE RELEASE MY RECORDS:

❑ TO ❑ FROM ❑ TO ❑ FROM

DR. _____ DR. _____

Practice Name: _____ Practice Name: _____

Address: _____ Address: _____

Address: _____ Address: _____

This form is valid for an indefinate period of time unless otherwise notified in writing by the patient or patient's responsible party.

This information is being disclosed to the above person, organization or agency from records whose confidentiality may be protected by the Federal Public Law 93-282. Information disclosed from this authorization might be redisclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act if the recipient is not a covered entity.

DATE OF RECORDS: _____

TYPE OF RECORDS: _____

_____

_____ _____

SIGNATURE OF RESPONSIBLE PARTY WITNESS

_____

If signed by a Legal Representative, Describe Authority to Act on Patient's Behalf

PERMANENT TRANSFER OF RECORDS ❑ YES ❑ NO

REASON FOR TRANSFER _____

FOR OFFICE USE ONLY

CHART # _____ PHYSICIAN _____

DATE RECEIVED _____ DATE SENT _____ BY _____