

**TOWN CENTER ORTHO ASSOC (TCOA) 1860 TOWN CENTER DRIVE #300**  
**RESTON, VA 20190 Ph 703-435-6604 Fax 703-787-6575**

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

\_\_\_\_\_  
(Print patients full name)

\_\_\_\_\_  
Birth date (Mo/Day/Yr)

\_\_\_\_\_  
(Street address)

\_\_\_\_\_  
Social security number (optional)

\_\_\_\_\_  
(City, state, zip code)

\_\_\_\_\_  
Phone (Home)

\_\_\_\_\_  
(Parent/Guardian if Patient < 18 yrs)

At the request of the individual, I \_\_\_\_\_, do hereby authorize **TCOA** to release:

Patient Name \_\_\_\_\_

SERVICE DATES OF \_\_\_\_\_

\_\_\_\_\_  
OPERATIVE NOTES    RADIOLOGY REPORTS    ENTIRE CHART    PHY THERAPY  
\_\_\_\_\_  
OFFICE NOTES    LAB/PATH REPORTS    SPECIFIC INJURY

\_\_\_\_ I do    \_\_\_\_ I do NOT    authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

**INFORMATION  
RELEASED TO:**

\_\_\_\_\_  
Name of Company/Agency/Facility/Person

\_\_\_\_\_  
Street address

\_\_\_\_\_  
City, state, zip

\_\_\_\_\_  
e-delivery available to patient's personal email, must complete additional form available from TCOA

**PURPOSE OF DISCLOSURE:**

\_\_\_\_\_  
REFERRAL TO SPECIALIST    INSURANCE    WORKERS COMP    LEAVING PRACTICE  
\_\_\_\_\_  
LEGAL INVESTIGATION    DISABILITY DETERMINATION    PERSONAL    RELOCATION/MOVING  
OTHER (SPECIFY) \_\_\_\_\_

**Please provide preferred telephone number in the event we need to contact you:** \_\_\_\_\_

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

**NOTE: HEALTHPORT WILL PROVIDE ONE COPY OF RECORDS FOR PERSONAL USE, OR CONTINUING CARE AT NO CHARGE. RECORDS WILL BE SENT BY STANDARD MAIL. HEALTHPORT DOES NOT FAX. IF APPLICABLE, VA STATE RATES APPLY. PGS 1-50, \$0.50 EACH, PGS 51+ \$0.25 EACH, PLUS POSTAGE.**

\_\_\_\_\_  
Signature of individual or guardian or  
Personal Representative of patient's estate    Power of Attorney Must Be Attached

\_\_\_\_\_  
Date

**MEDICAL INFORMATION RELEASED BY HEALTHPORT**

ENTIRE \_\_\_\_\_ LAB \_\_\_\_\_ EKG \_\_\_\_\_  
DS \_\_\_\_\_ EKG \_\_\_\_\_ IMMUNE \_\_\_\_\_  
OP \_\_\_\_\_ X-Ray \_\_\_\_\_ OTHER \_\_\_\_\_  
HP \_\_\_\_\_ PATH \_\_\_\_\_  
ROI SPECIALIST \_\_\_\_\_  
DATE \_\_\_\_\_