

Attachment III

Authorization to Release Confidential Medical Information

I, _____ DOB ____/____/____ SSN ____/____/____
Address _____ City _____
State _____ Zip Code _____ Phone (____) _____

() authorize Orthopedic Specialty Clinic, LTD., 2800 Wellford St., Suite 100, Fredericksburg VA. 22401, 540-361-1830, to release the information specified below, in accordance with the laws of Commonwealth of Virginia, and Orthopedic Specialty Clinic LTD., policies, to the party identified below or
() authorize the party identified below to release the specified information to Orthopedic Specialty Clinic LTD., 2800 Wellford St., Suite 100, Fredericksburg VA. 22401, 540-361-1830.

Release of Information to Person/Organization as noted below
Release of Information by Person/Organization as noted below

Name _____
Organization _____
Street Address _____
City, State, Zip Code _____

Information To Be Released/Obtained

Physician's Progress Notes _____ Radiology Report _____
Final Discharge Summary _____ Consultation _____
Emergency Room Reports _____ Complete Chart* _____
History and Physical _____ Psychiatric Records* _____
Laboratory Results _____ Drug & Alcohol* _____
HIV records* _____
Other (please specify) _____

*Complete chart requests do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.

Dates of Service _____ to _____ Medical Record # _____

The purpose for the disclosure of the above information is:

_____ Continuing Care
_____ Personal use
_____ Other _____
(Please designate other purpose)

VA law allows for copy charges consisting of the following: \$10.00 administrative fee PLUS \$0.50 per page for the first 50 pages and \$0.25 per page thereafter, and \$1.00 per page of microfilm/fiche

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Orthopedic Specialty Clinic, LTD., from, and covenant not to sue Orthopedic Specialty Clinic, LTD for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as: _____

Patient Signature: _____ Date ____/____/____
Parent/Guardian/Patient Designee Signature: _____ Date ____/____/____
Authority of Individual Signing For Patient: _____
Witness Signature: _____ Date ____/____/____