



Authorization to Use or Disclose Protected Health Information

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Appointments
434.485.8598

MRI/Bone Density
434.485.8521

Hand and Physical Therapy
434.485.8517

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434.485.8500
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Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Telephone Number: _____
Address: _____

This authorization permits The Orthopaedic Center of Central Virginia, Inc. to send my protected health information to:

Name: _____
Address: _____
Reason for Request of Medical Records: _____

Description of the information to be used or disclosed:

- Specific Medical Information (check all that apply):**
 - Dictated Office Notes
 - X-Ray Reports (Including MRI, CT Scan, Bone Scan)
 - Lab Results
 - Hospital Record (Including H&P, Operative Note, Discharge Summary, ER Note, Consult Note)

OR

- Specific Medical Information Related To:**
 - Date of Service: _____
 - Specific Condition: _____

- X-Rays (fee prepayment required) Please contact an x-ray technician assistant to determine required fee amount if you select this box.**

This authorization shall remain in effect one (1) year from the date of the request unless otherwise specified.

I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date. In order for the revocation of this authorization to be effective, The Orthopaedic Center of Central Virginia, Inc. must receive the revocation in writing. The revocation takes effect the date of the patient and practice signatures. ALL revocations must be sent to The Orthopaedic Center of Central Virginia, Inc. to the attention of the Privacy Officer and are not effective until received and signed by the Privacy Officer. I fully understand and accept the terms of this authorization.

Patient or Legal Guardian Signature

Date