



OFFICE USE
OA Employee Initials _____
Patient Account # _____

**TOWSON ORTHOPAEDIC ASSOCIATES RELEASE FORM
AUTHORIZATION INVALID UNLESS ALL FIELDS COMPLETE**

Today's Date: _____

TOA Physician Name: _____

* Patient Name: _____

* Patient's Date of Birth: _____

* Guardian Name: _____

Guardian /Patient's Phone Number: _____

*** INFORMATION TO BE RELEASED:**

STARTING DATE of service: _____ including (check all that apply)

- | | | |
|------------------------------------|---|-------------------|
| _____ ALL Medical Records | _____ Medical Records & Radiology Films | _____ FILMS Only |
| _____ Office Notes Only | _____ Disability Forms | _____ Lab Reports |
| _____ Radiology Reports | _____ Operative Notes | |
| _____ Other (please specify) _____ | | |

* **PURPOSE OF RELEASE:** _____ Legal _____ New Doctor/2nd Opinion _____ Other

* **RELEASE RECORDS TO WHOM & THEIR ADDRESS:** (please check one below)

_____ Records To Patient Or Guardian _____ Records Will Be Picked Up At The Office

(Physician, Hospital, Agency) _____

(Address) _____

(City, State, Zip) _____

Fax records to: _____

* I agree to pay the following: Administrative Processing Fee \$22.18, Printing Fee \$0.73 per page, Actual Shipping and Handling (this fee will be waived if picked up in person).
Records will only be processed upon payment received. Records will be processed within two weeks of payment received.

* I hereby authorize disclosure of health information for the above named patient. 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 redisclose by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. This authorization expires on _____, 20 _____ OR one year following the date signed below.

Please return all films to our office once you are finished with them.

*** CHECK ONE:**

* _____ I Do _____ I Do Not Authorize The Release Of Aids/hiv/drug Abuse Records.

* Guardian (Or) Patient Signature _____

* Date Of Release: _____