

**Winchester Orthopaedic Associates, Ltd.**

128 Medical Circle, Winchester, VA 22601 · Phone (540) 667-8975 · Fax (540) 667-6589

**AUTHORIZATION FOR RELEASE OF HEALTH RECORDS & X-RAYS · FORM COMPLETION REQUEST**

Winchester Orthopaedic Associates, Ltd. (WOA) recognizes the sensitive nature of our patients' Health Records. We require proof of identification or legal authorization prior to the release of any patient information to protect our patients' right to privacy. Our organization's HIPAA Privacy Notice is made available to all patients. WOA only accepts requests for Health Records in writing. This form must be COMPLETED, SIGNED and DATED before the request will be completed. [VA Code Sections: 54.1-2403.3; 32.1-127.1:03; 8.01-413]

**Date of Request:** \_\_\_\_\_ **Date Required:** \_\_\_\_\_ **Physician:** \_\_\_\_\_

**Patient Name** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_ **S.S.#:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **Work #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**E-mail address:** \_\_\_\_\_ (used only if records requested electronically)

**Parent/Guardian Name if Patient under 18 yrs.:** \_\_\_\_\_

**Purpose of Request:**

☐ **Health Records Release**

☐ **X-Ray Images on CD Release**

☐ **Form Completion**

**Dates of Service:** \_\_\_\_\_ **to** \_\_\_\_\_

-OR-

☐ **Last Two (2) Years**

☐ **Entire Record**

☐ **Office Notes**

☐ **Surgical Reports**

☐ **Radiology Reports**

☐ **Lab/Pathology Reports**

☐ **Other:** \_\_\_\_\_

**Consent for Release of Health Records/X-Rays:**

**Release to:** ☐ Patient ☐ Physician ☐ Other: \_\_\_\_\_ **Send Records by:** ☐ Mail ☐ Fax ☐ Secure E-mail/CD

**Send Records/X-Rays/Forms to (Name):** \_\_\_\_\_ **Appt. Date:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_ **E-mail:** \_\_\_\_\_

☐ **I do** ☐ **I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), STIs (Sexually Transmitted Infections), Adoption, Genetic Testing, Psychiatric care and/or Psychological Assessment, and treatment of Alcohol and/or Drug abuse.

**FEE SCHEDULE**

Once a request has been made, charges for this service are your responsibility. Payment is expected before forms or records will be released.

**HEALTH RECORDS:** **\$6.50**

*\*No charge if sent to another medical office*

**FORMS:** **\$20.00**

**X-RAY IMAGES on CD:** **\$15.00**

**OFFICE USE ONLY:**

*Records (Mailed/Faxed/Electronic) = **\$6.50***

# \_\_\_\_\_ Forms x \$20.00= \_\_\_\_\_

# \_\_\_\_\_ X-Rays on CD x \$15.00= \_\_\_\_\_

Your signature below indicates that you consent to the release of your health record and/or x-rays, or are requesting form completion, and agree to pay the fees identified above. This authorization is limited to one (1) year from the date of signature.

**Patient (or Parent/Guardian) Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Winchester Orthopaedic Associates has retained a professional service, HealthMark, to handle the duplication and transfer of medical records. Please return this form to Winchester Orthopaedic Associates for processing.

**MAIL:** Winchester Orthopaedic Associates

**FAX:** 540-667-6589 or 540-667-6291

128 Medical Circle

Winchester, VA 22601

\*For questions regarding the status of your request, please call: **540-667-8975, option 6**

Your request for forms, records or x-rays will be completed within 10 days of receipt of the request. If you request only the electronic portion of your chart, you may receive your information faster.

**OFFICE USE ONLY:** ☐ Workers' Comp ☐ PHI Log **TOTAL fees \$** \_\_\_\_\_ **Rec'd by (Int.):** \_\_\_\_\_ **Date Paid:** \_\_\_\_\_