OrthoVirginia
West End Orthopaedic Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
From OrthoVirginia

Patient Name: _____
(complete "legal" name including Jr., Sr., I, II, III)

Date of Birth: _____ **Social Security Number**: _____

I, _____ hereby authorize and request OrthoVirginia to release by mail/fax copies of:

☐ All medical records

☐ All x-rays (*mail or pick up only*)

☐ Medical records pertaining to the treatment of: _____
(specific problem or injury)

☐ X-rays (*mail or pick up only*) pertaining to the treatment of: _____
(specific problem or injury)

To: _____
(name of physician, practice or facility)

Address: _____

_____

Phone number: _____ Fax number: _____

I understand that I have the right to access my medical records in accordance with the law and the policies of OrthoVirginia. I understand that OrthoVirginia may charge me for copies of my medical records.

I understand that OrthoVirginia has the right to deny me access to my records in certain circumstances in accordance with the law. If OrthoVirginia denies me access to my medical information, I understand it will provide me with the reason for the denial in writing and describe whether I have the right to have a review of the denial preformed by a licensed care professional.

Please note that information disclosed pursuant to the request is no longer under the control of OrthoVirginia and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Patient or legal representative signature: _____
(if not the patient, please provide relationship, POA, etc,)

Date: _____