TWIN CITIES ORTHOPEDICS

Internal Use Only | Account #_____
Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:		
	DOB: / /	PREVIOUS NAME(S):	
2. RELEASE MY RECORDS FROM	FACILITY NAME:		
	DR. NAME:		
3. SEND MY RECORDS TO	NAME:	ATTN TO:	
	ADDRESS:		
	CITY:	STATE:	ZIP:
	PHONE:	FAX (For Continuing Care ONLY):	
	EMAIL: (Only if you want records sent via encrypted email)		
4. TYPES OF RECORDS	BODY PART:		
	DATE(S) OF SERVICE:		
	☐ Office Notes ☐ Radiology Reports ☐ Lab Reports	☐ Hospital Reports ☐ Therapy (Occupational or Physical)	
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____		
	"Verbal disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section:		
6. REASON FOR REQUEST	☐ Personal Use ☐ Disability	☐ Insurance ☐ Legal	☐ Workers Compensation ☐ Continuing Care
	Do you need imaging studies? ☐ Yes ☐ No (All images will be sent via email)		
7. RETURN COMPLETED FORMS TO:	**MAIL TO:** Treating Clinic Location (see details at **TCOmn.com/Locations**)	**EMAIL TO:** recordsrelease@TCOmn.com **FAX TO:** 952-456-7020 **DROP OFF:** Treating Clinic Location	
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	• I may revoke this authorization at any time by notifying the facility identified above in writing. • By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. • There may be a fee for release of this information and I may be responsible for that fee. • I am authorizing the release of my personal protected health information to and from the entities I've indicted above • Treatment will not be denied to me if I do not sign this form. • This authorization will expire one year from the date I sign on this form. SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.		