Wardell Orthopaedics, P.C.
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# Authorization for Release of Medical Records

Please note that the law allows the physician two weeks to comply with your request. It also permits the office to charge a reasonable fee for preparing records and photocopying.

PATIENT ID:_____

PATIENT'S NAME:_____ OTHER ID:_____

PATIENT'S ADDRESS: _____

SSN: _____DOB: _____HOME#_____CELL# _____

I request that my medical records be released to:

- ❑ Wardell Orthopaedics, P.C.
- ❑ Self
- ❑ Physician:_____ Fax#:_____
- ❑ Mail records to: _____
- ❑ Other, Please Specify: _____
  _____

I request the following medical information be released:

- ❑ Entire Chart
- ❑ Physical Therapy Notes
- ❑ Office Notes
- ❑ Appointment information - verify, cancel and schedule for patient
- ❑ Other, Please Specify:_____

I understand that I have a right to revoke this authorization at any time. Please see our Privacy Official for instructions as to how to revoke this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date: _____. If I fail to specify an expiration date, this authorization will expire in one (1) year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Wardell Orthopaedics, P.C. Privacy Official at (757) 215-1400.

PATIENT SIGNATURE:_____ DATE: _____

_____
If Signed by Legal Representative, Relationship to Patient