

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

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Harbour Sports Medicine • Harbour Rehabilitation