Bone & Joint Specialists
of Winchester, P.C.

152 Linden Drive, Winchester, VA 22601
Phone: 540-667-9252 Fax: 540-722-4514

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(please print)

PATIENT: _____ DATE: _____

ADDRESS: _____

PHONE: ( ) _____ DATE OF BIRTH: _____

BJSW ACCT. No. _____ SSN: _____

Records are to be obtained from:

Name of Doctor/Hospital: _____
Address: _____

Records are to be released to:

Name of Doctor/Hospital: _____
Address: _____

Records requested:

- ☐ office notes
- ☐ operative notes
- ☐ consultation reports
- ☐ pathology reports
- ☐ x-ray reports
- ☐ discharge summary
- ☐ office x-rays
- ☐ other _____

Dates of Service: *(from)* _____ *(to)* _____

This section must be signed by the patient or legal guardian.

I understand that my record may contain sensitive information concerning use of controlled substances, HIV status, sexually transmitted disease, blood alcohol levels, psychiatric examinations or other medical information usually contained in a patient history. My signature indicates my authorization to release these records.

I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but it will affect any information released prior to notification of cancellation. I understand the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Patient's Signature Parent or Legal Guardian, if patient is a minor

Records Released on: _____ by: _____