Winchester Orthopaedic Associates, Ltd.

128 Medical Circle, Winchester, VA 22601 – Phone 540.667.8975 / Fax 540.667.6589

AUTHORIZATION FOR RELEASE OF HEALTH RECORDS & X-RAYS
FORM COMPLETION REQUEST

Winchester Orthopaedic Associates, Ltd. (WOA) recognizes the sensitive nature of our patients' Health Records. We require proof of identification or legal authorization prior to the release of any patient information to protect our patients' right to privacy. WOA only accepts requests for Health Records in writing. Prior to signature on this form, WOA provides our organization's HIPAA Privacy Notice.

Date of Request:____________________ **Date Required:**____________________ **Physician:**____________________

Patient Name:____________________________ **D.O.B:**_________________________ **S.S.#:**____________________

Address:________________________________**City:**_______________________**State:**______**Zip Code:**__________

Home #:___________________ **Cell #:**___________________**Work #:**________________ **Fax #:**________________

E-mail address: ____(used only if records requested electronically)

Parent/Guardian Name if Patient under 18 yrs.: ____

Purpose of Request:

___ **Health Records Release** **Dates of Service:** ____________ **to** ____________ *-OR-* ___**Last Two (2) Years**

___ **X-Ray Images Release** ___Entire Record ___Office Notes ___Surgical Reports ___Radiology Reports ___Lab/Path Reports

___ **Form Completion** ___Other: ____

Consent for Release of Health Records/X-Rays:

Release for: ____**Personal Use** _____**Other:** ____

Send Records by (check one)**:** ____ **Mail/Fax** ____ **NextMD** (secure electronic transmittal)

Send Records/X-Rays to (Name):_______________________________________ **Appt. Date:** ____________________

Address:________________________________**City:**_______________**State:**______________**Zip Code:**_________

Phone #: _________________________________ **Fax #:** _________________________________

___**I do** ___**I do NOT** authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus), STIs (Sexually Transmitted Infections), Adoption, Genetic Testing, Psychiatric care and/or Psychological Assessment, and treatment of Alcohol and/or Drug abuse.

FEE SCHEDULE

Once a request has been made, charges for this service are your responsibility. Payment is expected before forms or records will be released.

HEALTH RECORDS

Cost per page:	**$0.50**	1-50 pages
	$0.25	51+ pages
	$1.00	Records on Microfiche

FORMS: **$20.00**

**Please allow up to 15 business days*

X-RAY IMAGES on CD: **$25.00**

**For X-rays taken prior to May 2012 (film) – please call our Medical Records department for further information: 540.667.8975, x316.*

OFFICE USE ONLY:
#_____pg @ $0.50 = _________
#_____pg @ $0.25 = _________
#_____pg @ $1.00 = _________
#_____ Forms x $20.00= _________
#_____ CDs x $25.00= _________

Invoices must be paid before records are released. Payment options: Check, Credit Card or Money order

Questions about your requests or invoice can be answered by calling Bactes at 1-(877)-270-4365.

Your signature below indicates that you consent to the release of your health record and/or x-rays, or are requesting form completion, and agree to pay the fees identified above. This authorization is limited to one (1) year from the date of signature.

Patient (or Parent/Guardian) **Signature:** ____ **Date:**________________

OFFICE USE ONLY: ☐ Workers' Comp ☐ PHI Log (date): __________ ☐ *Search & Handling fee + $10.00* ***TOTAL fees $***___________

[VA Code Sections: 54.1-2403.3; 32.1-127.1:03; 8.01-413] ***Date Paid:***__________ ***Rec'd by (Int.):***________