ORTHOPAEDIC ASSOCIATES
OF CENTRAL TEXAS
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT IDENTIFICATION	Patient Name _____ Date of Birth _____ Address _____ City, State, Zip _____ Telephone No. _____ Social Security No. _____

I request and authorize Orthopaedic Associates of Central Texas to release medical information of the patient named above.

RELEASE RECORDS TO: (Where records should be sent) ☐ **Fax** ☐ **Mail** ☐ **Pick up in person**

☐ **Same address as above**

Name/Agency _____

Address, City, State, Zip _____

Phone Number _____ Fax Number _____

RELEASE RECORDS FROM:

Name/Agency _____

Address, City, State, Zip _____

Phone Number _____ Fax Number _____

MEDICAL RECORDS TO INCLUDE	Dates of Treatment to be Released: _____ to _____
	☐ History and Physical Exam ☐ X-Ray Copies** ☐ All Records ☐ Consultations ☐ MRI Copy** ☐ Medications ☐ Other (specify) _____ ☐ Progress Notes ** **All imaging on CD only; $10 fee to be paid at time of record request**

PURPOSE OF RELEASE	
	☐ Patient Care ☐ Appointment sharing with other healthcare provider ☐ Personal Use ☐ Disability/Insurance Application/Claim ☐ Administrative (i.e. FMLA) ☐ Attorney/Legal Case ☐ Military ☐ Other (specify) _____

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical records department. 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.
3. Medical Practice Act 159.006-Upon receipt of a proper written request, **the office has 15 business days to release a copy of the medical records**. TSBME Rules 165.2 (b) - The requested copies of records shall be furnished by the office within 15 business days after the date of receipt of the request.
4. I understand that my medical records may contain copies of information received from other healthcare facilities and due to Federal Regulations those records must be released from the original medical facility and not from Orthopaedic Associates of Central Texas.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Relationship to Patient Witness