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. Our organization's HIPAA Privacy Notice is made available to all patients. WOA only accepts requests for Health Records in writing. This form must be COMPLETED, SIGNED and DATED before the request will be completed. *[VA Code Sections: 54.1-2403.3; 32.1-127.1:03; 8.01-413]*

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 **___ X-Ray Images on CD Release** **___ Form Completion**

Dates of Service: _____________ to _____________ *-OR-* **___Last Two (2) Years**
___Entire Record ___Office Notes ___Surgical Reports ___Radiology Reports ___Lab/Path Reports
___Other: ____

Consent for Release of Health Records/X-Rays:

Release to: __Patient __ Physician __Other:_________________ **Send Records by:** __Mail __Fax __ Secure E-mail/CD
Send Records/X-Rays to (Name)**:____ Appt. Date:** _______________
Address:____City:______________________State:_____Zip Code:__________
Phone #: ___________________________ **Fax #:** ___________________________ **E-mail:** ___________________________________

___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: **$6.50**
**No charge if sent to another medical office*

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 office for further information: (540) 667-8975, x316*

OFFICE USE ONLY:
Records (Mailed/Faxed/Electronic) = ***$6.50***
#_____ Forms x $20.00= _________
#_____ X-Rays on CD x $25.00= _________

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:_________________**

Winchester Orthopaedic Associates has retained a professional service, Record Reproduction Services (RRS), to handle the duplication and transfer of medical records. Please submit this form to RRS via one of the following methods:

MAIL: Record Reproduction Services (RRS)
600 North Jackson St., Suite 104
Media, PA 19063

EMAIL: status@rrsmedical.com

FAX: 540-301-5832

Your request for records or x-rays will be completed within 10 days of receipt of the request. If you request only the electronic portion of your chart, you may receive your information faster. **For questions regarding the status of your request, please call: 540-215-0400**.

OFFICE USE ONLY: ☐ Workers' Comp ☐ PHI Log ***TOTAL fees $_______________ Rec'd by (Int.):_________ Date Paid:__________________***