Anderson Orthopaedic Clinic SINCE 1941
Orthopaedics, Physical Therapy and Urgent Care

www.andersonclinic.com Phone (703) 892-6500 Fax (703) 521-3415
ARLINGTON | MOUNT VERNON | LORTON | FAIRFAX | RESTON

Medical Records Request & Release Form

* All items with an asterisk are MANDATORY fields.

* Patient Name	
* Patient Date of Birth	
* Patient Address	
* Contact Phone Number	
* Contact Email	

* I authorize Anderson Orthopaedic Clinic to (check one):
  - ☐ **RELEASE** the information indicated to:
  - ☐ **REQUEST** the information indicated from:

_____
* Name of person or entity to receive or disclose information

_____
Street Address City State Zip

_____ _____ _____
Phone Fax Email

* Dates of treatment requested:
  - ☐ All dates
  - ☐ Specific dates: _____

* Records Requested (check all that apply):
  - ☐ Complete Medical Record
  - ☐ Billing Information
  - ☐ Progress Notes
  - ☐ X-ray Images
  - ☐ Operative Notes
  - ☐ Laboratory Reports
  - ☐ Physical Therapy Reports
  - ☐ Other (specify): _____

* Purpose (check all that apply):
  - ☐ Insurance
  - ☐ Personal Use
  - ☐ Other (specify): _____
  - ☐ Insurance
  - ☐ Transfer of Care
  - ☐ Attorney

* Provide Records utilizing (check one):

- ☐ Patient Portal (no X-ray)
- ☐ Fax (no X-ray)
- ☐ Mail - USPS
- ☐ Mail - Expedited (fees covered by requester)
- ☐ Pick-Up
- ☐ Email (Encrypted)

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA regulations, the information described above may be redisclosed and will no longer be protected by these regulations.

I understand that I may revoke this authorization, in writing, at any time.

I understand that neither the Anderson Orthopaedic Clinic nor its physicians will condition treatment, payment, enrollment, or eligibility for benefits on whether or not this authorization is signed.

_____ _____

* Patient or Authorized Representative (SIGNATURE)

* Date/Time
(Authorization will expire twelve months from date signed)

_____ _____

* Patient or Authorized Representative (PRINTED NAME)

* Relationship to Patient