

# Commonwealth

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## Orthopaedics

Getting back to **your** life.

### Authorization To Release Protected Health Information

**I hereby authorize the release of Protected Health Information**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Social Security Number \_\_\_\_\_

**Information being released to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

**Information being released from:**

Name: Commonwealth Orthopaedics & Rehabilitation, PC

Address \_\_\_\_\_

**Reason for release of Protected Health Information:**

\_\_\_\_\_

**Description of Protected Health Information to be released:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I understand that:**

\_\_\_\_\_ I may revoke this consent in writing at any time except to the action that has already been taken.

\_\_\_\_\_ The information released is for the specific purpose stated above.

\_\_\_\_\_ This consent will expire 30 days after the date of my signature unless otherwise specified.

\_\_\_\_\_ The information may be subject to re-disclosure by the recipient and thus no longer be protected by HIPAA regulations.

\_\_\_\_\_ By Virginia statute, the practice has up to 15 days to prepare and release my records.

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Witness \_\_\_\_\_