

**Potomac Valley Orthopaedic Associates, Chtd.
Release of Medical Information**

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

Describe the purpose of this authorization to release information:

At the request of the patient

Other: _____

I hereby authorize and request Potomac Valley Orthopaedic Associates, Chtd. to release the following information to:

Name: _____

Address: _____

City, State/Zip: _____

Telephone Number: _____

Medical Records in your possession concerning my illness and/or treatment in your facility for the following time period(s): _____

State specific information needed: _____

X-rays requested? _____ Yes _____ No

This authorization expires on: _____ / _____ / _____, or when the following event occurs:

_____, but not more than one year.

For contracts issued in the State of Maryland, I understand that this authorization shall be valid for a period not to exceed one year.

I understand that a fee may be charged for duplication of records and x-rays. Charges will be provided prior to duplication.

I understand that the policy of Potomac Valley Orthopaedic Associates is that any copied records may not be duplicated.

Patient's Signature

_____/_____/_____
Date

OR

Patient's Representative

_____/_____/_____
Date

REVOCAATION

Reason: _____

Patient Signature: _____ Date: _____ / _____ / _____