HESS ORTHOPAEDICS & SPORTS MEDICINE, PLC

4165 Quarles Court
Harrisonburg, VA 22801
Phone: (540) 434-1664 - Fax: (540) 437-7581

Records Release

Date_____

To: _____

Phone:_____ **Fax:**_____

Address:_____

_____

I hereby authorize you to release to:

Hess Orthopaedics & Sports Medicine, PLC, 4165 Quarles Court, Harrisonburg, VA 22801

Information including the records of any treatment rendered to me during the period

from_____**to**_____.

_____ _____
(Signature) **(SSN or DOB)**

_____
(Witness)

For Office Use Only:

*Date Records Released:*_____ *Staff Initial:*_____

Hess Orthopaedic Center & Sports Medicine, PLC
Medical Records
4165 Quarles Court
Harrisonburg, VA 22801
Phone: (540) 434-1664 – Fax: (540) 437-7581

Authorization to Release Medical Records from Hess Orthopaedic Center

Patient Name:_____ DOB:_____
(Print Full Name)

This authorizes *Hess Orthopaedic Center & Sports Medicine, PLC* to provide a copy, summary, or narrative of my medical records as indicated by the checkmark(s) below, or otherwise release confidential information.

- ☐ Complete Record
- ☐ Records of care from the following dates:_____ to_____
- ☐ Records concerning the following conditions:_____
- ☐ Other, please specify:_____
- ☐ Confer with person(s) listed below orally about my medication information:

Requested by:_____
The reasons or purposes for this release of information are as follows:
_____
_____
Release to the following person(s):
Name:_____
Street:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____
Expiration date_____or Expiration Event as detailed below:

- I understand that *Hess Orthopaedic Center & Sports Medicine, PLC* will provide this information within 15 days from receipt of request and that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Virginia Statutory Code.
- I understand that I may revoke this authorization in writing at any time by notifying *Hess Orthopaedic Center & Sports Medicine, PLC* in writing. Revoking this authorization will not affect the use or disclosures of my confidential information that occurred prior to revoking.
- I understand that refusal to sign this authorization will not in any way affect my treatment.
- I understand that confidential information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- I agree to be responsible for and pay the fee for providing copies of my medical information.

Patient Signature:_____ **Date:**_____
*For Office Use Only: Date Records Released:*_____ *Staff Initial:*_____