COUNTRYSIDE ORTHOPAEDICS, PC
19465 Deerfield Avenue, Suite 405, Leesburg, VA 20176 **FAX (703) 858-1801**

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____
Last First Middle

Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____

If person making request is not the patient, complete this section:

Name: _____
Last First Middle

Relationship to Patient : _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____

***I request and authorize COUNTRYSIDE ORTHOPAEDICS, PC, to release healthcare information of the patient named above to*:**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Please describe the purpose of disclosure:

☐ Referral to specialist ☐ Insurance ☐ Worker's Comp ☐ Change of Doctor/Provider

☐ Legal Investigation ☐ Self ☐ Continuing Care ☐ Disability Determination

☐ Other (please specify): _____

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

_____ _____ _____
Signature (Patient or Representative) Printed Name Date Signed