We have received a request for a copy of your medical record. Please find attached an authorization allowing us to release your protected health information. Fill this form out completely and mail, fax or bring this form back to:

OrthoVirginia
2405 Atherholt Road
Lynchburg, Virginia 24501
FAX: (434) 485-8599

Please note that we have up to 15 business days from the receipt of your release form to process your request. Failure to complete this form entirely will delay your request. The release forms are processed on a first come/first serve basis.

Need your records sooner?

Please sign up for our Next MD Patient Portal. This portal will allow us to send your medical records to you within 3 business days.* (See someone at the front desk for sign up instructions or call the Health Information Department)

If you should have any questions, please do not hesitate to contact our office.

OrthoVirginia - Lynchburg
Health Information Department

PH#: (434) 485-8536

*All medical records must be signed off electronically by the provider in order to release them.
HIPAA-Release of Information Form
Authorization to Use or Disclose Protected Health Information

Patient Name: ____________________________________________________________
Date of Birth: ___________ Age: _____ SS#: ________________________________
Address: ________________________________________________________________
City __________________________ State ___________ Zip Code _______________________

REASON FOR REQUEST: ____________________________________________________

***NOTE-For attorney requests, please have the Attorney send a request in writing to this office***

I GIVE PERMISSION TO RELEASE MEDICAL RECORDS BY THE FOLLOWING METHOD: (Check Appropriate Box)

- □ Self-(patient only @ address above)
- □ Fax#________________________ Attn: ________________________________
- □ Mail- Recipient Name: ____________________________
  Mailing Address: _______________________________________________________
- □ Pick up /Phone # __________________________ (You will be contacted once records are available)

I AM REQUESTING THE FOLLOWING MEDICAL RECORDS BE RELEASED:(check all that apply)

□- All Office Notes
□- Specific Date of Service________
□- Specific Condition/Body Part_______
□- Hospital Record-H&P, OP Note, Discharge Summary, ER Note, Consult
□- Other:___________________________
□- Physical Therapy Notes
□- Lab Results
□- X-Ray-Written Report-ORTHOVA, MRI, CT, Bone Scan Reports
□- X-ray Images-CD ($10.00 fee required)
□- Written Report
□- Other:___________________________

I have read this authorization and understand the designated information will be disclosed only to the recipient(s) outlined above. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization in writing at a later date. In order for the revocation of this authorization to be effective, Ortho Virginia must receive the revocation in writing. The revocation takes effect the date of the patient and practice signatures. ALL revocations must be sent to OrthoVirginia to the attention of the Privacy Officer and are not effective until received and signed by the Privacy Officer. I fully understand and accept the terms of this authorization. This authorization shall remain in effect one (1) year from the date of the request unless otherwise noted. This original form may be updated for other documents that need to be released at a later date/same entity. Your permission will be required.

_____________________________ _______________________
Patient/Legal Guardian Signature Date