

Call Patient to Schedule:



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| Internal Use Only   Account # _____<br>Pickup Instructions _____ |
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**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

|   |   |   |  |
|---|---|---|--|
| <b>1. PATIENT INFORMATION</b>   | <b>PATIENT NAME:</b> _____  |   |  |
|   | <b>DOB:</b> /     /   | <b>PREVIOUS NAME(S):</b> _____  |  |
| <b>2. RELEASE MY RECORDS FROM</b>   | FACILITY NAME: OSI Physical Therapy   |   |  |
|   | DR. NAME: _____   |   |  |
| <b>3. SEND MY RECORDS TO</b>  | NAME: TCO   Forest Lake   | ATTN TO: Physical Therapy   |  |
|   | ADDRESS: 1398 Lake Street S   |   |  |
|   | CITY: Forest Lake   | STATE: MN   | ZIP: 55025   |
|   | PHONE: 651-351-2602   | FAX (For Continuing Care ONLY): 651-309-0032  |  |
|   | EMAIL: (Only if you want records sent via encrypted email)  |   |  |
| <b>4. TYPES OF RECORDS</b>  | <b>BODY PART:</b> _____   |   |  |
|   | DATE(S) OF SERVICE: All related to above diagnosis  |   |  |
|   | Do you need imaging studies? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Images AND Records Below<br><small>(All images will be sent via email or pushed electronically to the outside entity listed)</small><br><input checked="" type="checkbox"/> Office Notes <input checked="" type="checkbox"/> Hospital Reports<br><input checked="" type="checkbox"/> Radiology Reports <input checked="" type="checkbox"/> Therapy (Occupational or Physical)<br><input type="checkbox"/> Lab Reports <input checked="" type="checkbox"/> Sports Physical   |   |  |
| <b>5. VERBAL DISCLOSURE</b>   | For verbal disclosure, check here: _____  |   |  |
|   | "Verbal disclosure" authorizes TCO to discuss my care with the person(s) indicated in this section:   |   |  |
| <b>6. REASON FOR REQUEST</b>  | <input type="checkbox"/> Personal Use<br><input type="checkbox"/> Disability  | <input type="checkbox"/> Insurance<br><input type="checkbox"/> Legal  | <input type="checkbox"/> Workers Compensation<br><input checked="" type="checkbox"/> Continuing Care |
| <b>7. RETURN COMPLETED FORMS TO:</b>  | <b>MAIL TO:</b><br>Treating Clinic Location<br>(see details at TCOmn.com/Locations)   | <b>EMAIL TO:</b> recordsrelease@TCOmn.com<br><b>FAX TO:</b> 952-456-7020<br><b>DROP OFF:</b> Treating Clinic Location |  |
|   | * Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.   |   |  |
| <b>8. I UNDERSTAND THAT BY SIGNING THE BELOW:</b>   | <ul style="list-style-type: none"> <li>I may revoke this authorization at any time by notifying the facility identified above in writing.</li> <li>By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed.</li> <li>There may be a fee for release of this information and I may be responsible for that fee.</li> <li>I am authorizing the release of my personal protected health information to and from the entities I've indicated above</li> <li>Treatment will not be denied to me if I do not sign this form.</li> <li>This authorization will expire one year from the date I sign on this form.</li> </ul> |   |  |
|   | <b>SIGNATURE:</b> _____ <b>DATE:</b> _____  |   |  |
|   | <b>PRINT NAME:</b> _____  |   |  |
| *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form. |   |   |  |

**\*Electronic or Typed Signatures cannot be accepted\***