Bone & Joint Specialists of Winchester, P.C.

Medical Office Building II
190 Campus Blvd., Suite 310 Winchester, VA 22601
Phone: 540.667.9252 • Fax: 540.722.4514 • www. BoneAndJointSpecialists.com

RICHARD J. PATTERSON, M.D.
DWIGHT T. KEMP, D.O.
BERNARD M. SWOPE, M.D.

JAMES W. LARSON, III, M.D.
THOMAS W. COURTNEY, M.D.
KELLI M. EGLINGER, PA-C
JOHN W. GHRAMM, M.D.
Director Ortho-Now Bone Health

W. ALEXANDER BRUENING, PA-C
LAURIE A. BITTING, PA-C
KATHRYN DURBIN, PA-C

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(please print)

PATIENT: _____ DATE: _____

ADDRESS: _____

PHONE: ( ) _____ DATE OF BIRTH: _____

B&J Specialists Acct. #: _____ SS#: _____

Records are to be obtained from:

Name of Doctor or Hospital: _____

Address: _____

Records are to be released to:

Name of Doctor or Hospital: _____

Address: _____

Records requested:

- ☐ office notes
- ☐ pathology reports
- ☐ office x-rays
- ☐ operative notes
- ☐ x-ray reports
- ☐ other _____
- ☐ consultation reports
- ☐ discharge summary

Dates of Service: *(from)* _____ *(to)* _____

This section must be signed by the patient or legal guardian:

I understand that my record may contain sensitive information concerning use of controlled substances, HIV status, sexually transmitted disease, blood alcohol levels, psychiatric examinations or other medical information usually contained in a patient history. My signature indicates my authorization to release these records.

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will effect any information released prior to notification of cancellation. I understand the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Patient`s Signature | Parent or Legal Guardian, if patient is a minor

Records Released on: _____ by: _____

Over 130 years of combined experience seving you.

Please Print and bring completed form to your visit.