



# THE ORTHOPEDIC CLINIC ASSOCIATION, P.C.

SERVING OUR PATIENTS THROUGH INNOVATIVE AND COMPREHENSIVE ORTHOPEDIC CARE

## INSTRUCTIONS FOR COMPLETING RELEASE FORM

- 1.) Completely fill out top portion with your information.
- 2.) Check 1<sup>st</sup> box if you would like TOCA to release your records.
- 3.) Check 2<sup>nd</sup> box if you would like TOCA to receive your records.
- 4.) Completely fill out the second portion with all the information requested for the provider/facility/person that will be receiving/releasing your records. Please make sure that provider's complete name, first & last, is listed.
- 5.) If you are requesting records be sent to you, it is also necessary to complete the 2<sup>nd</sup> part with all your information again.
- 6.) If requesting records to be Emailed, sign Email agreement on the 2<sup>nd</sup> page where indicated.
- 7.) Provide Email address in the boxes provided.
- 8.) Please sign and date at bottom of 2<sup>nd</sup> page.
- 9.) If requesting records be sent to TOCA, send the request directly to the provider/facility you are asking to release/send records to TOCA.
- 10.) If requesting TOCA to release records, return completed form to TOCA by Fax, Email or mail.
- 11.) Records requests from TOCA will normally be processed within 72 hours.

Unless the form is completely filled out, your request cannot/will not be processed. All information must be provided to ensure that records are released to the correct provider/facility per your wishes. Please note that TOCA has contracted with Quest HIMS to process your records request and you may be charged for this service.

Thank you,

Quest HIMS  
P#: 888-355-9550  
F#: 877-570-8002  
Email: info@questrecordsllc.com

- Gustavo J. Armendariz Jr., M.D.
- Joseph Blazuk, M.D.
- Kraig M. Burgess, D.O.
- Thomas R. Carter, M.D.
- P. Dean Cummings, M.D.
- Sherwood K. Duhon, M.D.
- Kostas Economopoulos, M.D.
- Richard J. Emerson, D.O.
- Earl L. Feng, M.D.
- Joseph L. Haber, M.D.
- Samuel M. Harmsen, M.D.
- Christopher W. Huston, M.D.
- Steen Johnsen, M.D.
- Evan S. Lederman, M.D.
- Grant D. Padley, D.O.
- William R. Stevens, M.D.
- Josh C. Vella, M.D.
- Gerald N. Yacobucci, M.D.
- Jon D. Zoltan, M.D.

ORTHOPEDIC SURGEONS FOR  
Arizona State University

OFFICES  
2222 East Highland Avenue  
Suite 300  
Phoenix, AZ 85016  
Tele (602) 277-6211

377 East Bell Road  
Suite 231  
Scottsdale, AZ 85260  
Tele (602) 277-6211

002 South Mill Avenue  
Tempe, AZ 85282  
Tele (602) 277-6211

320B West Union Hills Drive  
Suite B1800  
Glendale, AZ 85308  
Tele (602) 277-6211

845 E. Still Circle  
Suite 106  
Mesa, AZ 85206  
Tele (602) 277-6211

www.TOCAMD.com  
www.azcartilage restoration.com



2222 E. Highland Ave., Suite 300 · Phoenix, AZ 85016  
888-355-9550 · Fax 877-570-8002

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

NAME: \_\_\_\_\_ PID (If known) \_\_\_\_\_

PATIENT'S DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

PATIENT'S ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE#: \_\_\_\_\_ FAX#: \_\_\_\_\_

<b>PLEASE CHECK APPROPRIATE BOX</b>	<input type="checkbox"/> I hereby authorize TOCA to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
	<input type="checkbox"/> I hereby authorize THE PROVIDER LISTED BELOW to send / release photocopies of medical records concerning the above named patient to TOCA.

**NAME OF COMPANY / PHYSICIAN / AUTHORIZED PERSON \_\_\_\_ TO RECEIVE \_\_\_\_ RELEASE RECORDS)**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE#: \_\_\_\_\_ FAX#: \_\_\_\_\_

**DELIVERY METHOD FOR RELEASE OF RECORDS:**

- MAIL PAPER COPIES       MAIL CD/DVD DIGITAL COPIES       FAX COPIES       PICK UP CD/DVD DIGITAL COPIES
- PICK UP PAPER COPIES       EMAIL/ELECTRONIC DIGITAL COPIES – Please see page 2 of this release form for email authorization.

DIGITAL COPIES WILL BE PROVIDED IN PDF FORMAT. YOU CAN OBTAIN A COPY TO ADOBE READER AT <http://www.adobe.com/>

TREATMENT DATE(S) TO BE DISCLOSED: From \_\_\_\_\_ to \_\_\_\_\_

**DESCRIPTION OF INFORMATION TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) PROVIDED:**

- Abstract/Summary of Medical Records for personal or physician use       Complete Medical Records

**“OR” SPECIFIC DOCUMENT(S) TO BE DISCLOSED FOR THE ABOVE TREATMENT DATE(S) PROVIDED:**

- Clinic/Office Note(s)       Laboratory Report(s)       Diagnostic Test/Report(s)
- Consultation(s)       Operative Report(s)       Radiology CD/Film(s)
- Pathology Report(s)       Itemized Bill(s)       Other, specify \_\_\_\_\_

This information may include Medical/Surgical, Psychiatric, Substance Abuse, and HIV/AIDS information.

SPECIFIC INFORMATION NOT TO BE DISCLOSED: \_\_\_\_\_

**THIS INFORMATION IS TO BE USED/DISCLOSED FOR THE FOLLOWING PURPOSE(S): (check all that apply)**

- Continuation of Care     Patient Transfer     Legal     Insurance     Patient Personal Records
- Other- explain: \_\_\_\_\_

