



THE ORTHOPEDIC CLINIC ASSOCIATION, P.C.

SERVING OUR PATIENTS THROUGH INNOVATIVE
AND COMPREHENSIVE ORTHOPEDIC CARE

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ORTHOPEDIC SURGEONS FOR
Arizona State University

OFFICES

2222 East Highland Avenue
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Fed ID #86-0087236

www.TOCAMD.com

INSTRUCTIONS FOR COMPLETING RELEASE FORM

- 1.) Completely fill out the top portion with your information.
- 2.) Check 1st box if you would like TOCA to release your records.
- 3.) Check 2nd box if you would like TOCA to receive your records.
- 4.) Completely fill out second portion with all of 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 2nd part with all you information again.
- 6.) If requesting records to be emailed, please sign the "Email Acknowledgement Agreement" on the 2nd page where indicated.
- 7.) Provide email address in boxes.
- 8.) Please sign and date at bottom of 2nd page.
- 9.) If you are requesting to have your records sent to TOCA, send the attached forms directly to the provider/facility you are requesting 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.
- 12.) There is a fee for copies of medical records. The cost-based fee for patients is:

Pages 1-25	\$0.50 per page
Pages 26+	\$0.25 per page
CD/Digital	\$14.85 Flat Fee

Unless the form is completely filled out, request cannot/will not be processed. All information must be provided to insure records are released to correct provider/facility per your wishes.

Thank you, Medical Records Department
P#: 602-277-6211 Option 4
F#: 602-277-1074
Email: phxrecords@tocamd.com



2222 E. Highland Ave., Suite 300 · Phoenix, AZ 85016
Phone (602) 277-6211 Fax (602) 277-1074- Email: phxrecords@tocamd.com
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Last Name First Name Date of Birth

Street Address / Apt# (Include Complete Mailing Address) Social Security #

City State Zip Code Telephone Number

Check Appropriate Box:

- I hereby authorize TOCA to send / release photocopies of medical records concerning the above named patient to NAMED RECEIVER LISTED BELOW.
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 Fax Number

Street Address / Apt# or Suite (Include Complete Mailing Address) Telephone Number

City State Zip Code Fax Number

DELIVERY METHOD FOR DUPLICATION OF RECORDS:

- MAIL PAPER DUPLICATION MAIL CD/DVD DIGITAL DUPLICATION FAX DUPLICATION
PICK UP PAPER DUPLICATION EMAIL/ELECTRONIC DIGITAL DUPLICATION - Please see page 2 of this release form.
DIGITAL DUPLICATION WILL BE PROVIDED IN PDF FORMAT. YOU CAN OBTAIN A COPY TO ADOBE READER AT http://www.adobe.com/

TREATMENT DATE(S) TO BE USED/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 Legal Other- explain



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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

MAIL/ELECTRONIC DELIVERY NOTICE:

I understand Emails can be intercepted, altered, forwarded, or used without authorization or detected. Emails can be circulated, forwarded and stored in both electronic and paper formats. Email addresses can be incorrectly written or typed. Emails can be inadvertently exposed, lost during creation and transmission due to technical failure. I understand and accept the risk using an unsecure email. I agree for TOCA and/or ScanSTAT Technologies to email me my protected health information when the email delivery method is chosen and I fully understand the risk involved in using the email delivery method. PLEASE SIGN IF YOU AGREE AND ACKNOWLEDGE -

PLEASE PROVIDE AN EMAIL FOR ELECTRONIC DELIVERY

Grid for email address input

PLEASE PROVIDE A PREFERRED PASSWORD MUST CONTAIN 8 TO 12 CHARACTERS

Grid for password input

- Unless withdrawn, this consent will expire 90 days from the date signed unless another date or event is specified.
By signing this form, I agree to pay any duplication fees or charges for this information at the time of service or when applicable.
If preferred delivery method is unavailable at the time of service, I authorize that this information to be mailed or faxed.
I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the Medical Records Manager at The Orthopedic Clinic Association.
I understand that my revocation is not effective to the extent that the persons or organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature
I hereby authorize The Orthopedic Clinic Association and or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I hereby release The Orthopedic Clinic Association and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released via mail, fax, and/or electronic delivery.

I HEREBY RELEASE THE ORTHOPEDIC CLINIC ASSOCIATION, P.C. FROM ALL LEGAL RESPONSIBILITY OR LIABILITY THAT MAY ARISE FROM THE ACT I HAVE AUTHORIZED ABOVE.

Signature of Patient

Date

Parent / Legally Authorized Representative / Relationship to Patient

Date

Witness

Date

Reason patient was unable to sign release:

PATIENTS 18 YEARS AND OLDER MUST SIGN THEIR OWN RELEASE FORM