Medical Records Release Authorization

Medi-Copy Services, Inc. / 210 12th Ave Sth #201 Nashville, TN 37203
Phone: (615) 780-2741 / Toll Free: 866-587-6274 / Fax: (615) 780-9866

1. I hereby authorize Tennessee Orthopaedic Alliance to release or disclose to the below-named person or organization all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

This office uses an outside copy service, Medi-Copy Services Inc, to copy its medical records. All copy fees comply with applicable state law. Please make your check payable to Medi-Copy Services Inc, or by phone using your credit or debit card. Pursuant to Tennessee State law, Medi-Copy Services Inc. requires payment to be made prior to the completion of your request.

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2. PLEASE MARK ONE OF THE FOLLOWING

☐ I wish to have copies of the last 2 years of my records sent directly to another physician at no charge.

☐ I wish to have my records sent to the address or fax number listed in Sec. 3
There is a minimum copy fee of $25.35 (covers 1st 5 pages + postage, each additional page .50). Once copied, you will be pre-billed and your records will be sent once payment is received.

☐ For an additional $7.00, I wish to have my records put on a CD.

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3. ☐ **MAIL RECORDS OR FAX TO: (please print)**
☐ **RETRIEVE RECORDS FROM:**

_____

_____

_____

PATIENTS NAME AND ADDRESS:

_____

_____

_____

PATIENTS HOME #: _____

ID checked by:

ID checked at pick up by:

PATIENTS SS#: _____ **PATIENT DOB:** _____

PURPOSE OF DISCLOSURE: _____

INFORMATION TO BE RELEASED: _____

_____

This Authorization will expire ONE year following the date signed.

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4. If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise your records will be released as specified above.

* I authorize Tennessee Orthopaedic Alliance and any employees and/or agents to release the information specified to the organization, agency, or individual named on this request with the exception of:

Initials _____ Substance abuse, if any **Initials** _____ AIDS/HIV/STD'S, if any **Initials** _____ Psychological or psychiatric conditions, if any

* I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect of actions taken by Tennessee Orthopaedic Alliance and any employees and/or agents before they have received my revocation. Should I desire to revoke this Authorization, I must send written notice to Medi-Copy Service Inc. at the address shown above.

* I understand that I am not required to sign this Authorization. Tennessee Orthopaedic Alliance and any employees and/or agents will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization. * I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the ability of Tennessee Orthopaedic Alliance and any employees and/or agents to use or disclose my information for treatment, payment or heath care operations, or as otherwise permitted by law.

Patient or Authorized Representative's Signature: _____ **Date:** _____

Relationship to patient: _____

Witness Signature: _____ **Date:** _____