MediCopy Authorization for the Release Of Medical Records

Tennessee Orthopaedic Alliance

Tell us about the patient.

Name: DOB: SSN: XX-XX-

Email:

Address:

City: State: Zip:

Phone#: Fax#:

Where are we sending the records?

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

What would you like released?

Specific Categories

□ All Records □ Office/Clinic Notes □ Operative Reports

□ Radiology Reports □ Imaging CD/Download (MRI, CT, X-Ray, etc.) ***$20.00 fee required***

□ Dates _____ to _____ □ Other_____

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

Why are we sending the records?

Purpose of Disclosure

□ Personal Use □ Litigation/Legal □ Insurance □ Transfer of Care *(Last 2 Years Sent Unless Specified Above)*

****Per HIPAA 45 CFR 164.524, you may be charged a reasonable fee for reproducing medical records.*

*Fees are non-refundable once services are rendered. Payment is due on receipt of invoice.****

☐ ***I hereby acknowledge that I have read and agree to the fees listed within the state statute of the applicable state from where records are released. Fees are non-refundable once services are rendered. Payment is due on receipt of invoice and payments received after 30 days are subject to $5.00 late fee.***

How would you like the records sent?

Delivery Method*

The Following Delivery Methods are at No Additional Charge

Email ☐ Fax ☐ Pick-Up ☐ Postage (additional fee applies) ☐

Patient's Signature

I hereby authorize Medi-Copy and its affiliates to release or disclose to the person(s) or organization listed above, all medical records requested, including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection, *unless otherwise noted*. 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 not affect any information released prior to notification cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Patient's Signature: Date:

Relationship to patient: