MEDI-COPY
simple. secure. solutions.

Authorization to Release Medical Records

1) Records Released From:

Facility/Doctor's Name:

2) Patient Identification:

Patient Name: DOB: SSN: XXX-XX-

E-mail:
(pay online & receive records quicker)

Address:
(Street Address)

Phone #:

(City/State/Zipcode)

3) Release Records To:

☐ **Same as above**

Name:

Email:

Address:

City: State: Zip:

Phone#: Fax#:

4) Information Requested & Purpose of Disclosure: (*Fees may apply. Please see fee schedule*)

Specific Categories
☐ All Records
☐ Office/Clinic Notes
☐ Lab/Pathology Results
☐ Radiology Reports
☐ Immunization Records
☐ Other_____
OR Dates from:_____ to _____

Fee Schedule (if applicable)*			
Fees Reflect TN statute 63-2-102 revised 06/2010			
Pages 1-5	**$20.00**	**Pages 6+**	**$.50/page**
*** Please Note: Typically records sent from physician to physician are sent free of charge.*** (Some Exceptions Apply)*			
Delivery Method*			
The Following Delivery Methods are at No Additional Charge			
Email ☐		**Fax ☐**	**Pick-Up ☐**
Fees Listed are in Addition to Prices Listed in Fee Schedule.			
Postage ☐	**$6.00**	**Recs on CD ☐**	**$7.00**

Purpose of Disclosure:

☐ Transfer of Care (Last two years sent w/o charge) ☐ Personal Use ☐ Litigation/Legal ☐ Disability ☐ Insurance

5) Patient's Signature

I hereby authorize Medi-copy and its affiliates to release or disclose to the above-named person(s) or organization in **Section 3** 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:
Witness/Representative's Signature:	Date:
Relationship to patient:	