Tennessee Physical Medicine and Pain Management

MEDI-COPY simple. secure. solutions.

210 12th Avenue South #201 Nashville, TN 37203 / Phone: (615) 780-2741 / Fax (615) 780-9866 / www.medicopy.net

Authorization to Release Protected Health Information

Medi-Copy Services, Inc. is a health information management company that has partnered with Tennessee Physical Medicine and Pain Management to ensure a more efficient and timely process for fulfilling your medical records requests. Medi-Copy is fully HIPAA compliant and adheres to all state and federal regulations concerning protected health information.

1. PLEASE MARK ONE OF THE FOLLOWING

▫ I wish to have copies of my medical records transferred to another doctor for continuing care.

▫ I wish to have my medical records sent to the address or fax # listed in Section 3

▫ I wish to have my medical records released to me:

- ▫ Electronically via email: ________________________@____________.________
- ▫ on CD
- ▫ in paper form sent to address below ▼

Fee Schedule

Pages 1-5 = $20.00
Pages 5+ @ $0.50/pg
Plus applicable postage

I acknowledge that a fee may be charged for this request:_________

2. MAIL OR FAX RECORDS TO: PATIENTS NAME & ADDRESS:

Fax: (_______) ________ - _______________

Phone: (_______) ________ - _______________

PURPOSE OF DISCLOSURE

▫Personal Use ▫Second Opinion ▫Continued Care
▫Insurance ▫Attorney/Litigation

Email(required):____
(You will be emailed an invoice, if applicable.)
DOB: _________/_________/
SSN#: xxx - xx - ______________

INFORMATION TO BE DISCLOSED

▫All Records ▫Progress Notes ▫Labs/Lab Results
▫Imaging ▫Other: ______________________________

DATES OF SERVICE REQUESTED

_____/_____/_____ - _____/_____/_____

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 release. Otherwise you records will be released as specified above.

* I authorize the clinic/physician listed in Section 1 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 the clinic/physician listed in Section 1 and any employees and/or agents before they 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. The clinic/physician listed in Section 1 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 the clinic/physician listed in Section 1 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.

* **This Authorization will expire ONE year following the date signed.**

Patient or Authorized Representative's Signature: ____

Date: ______________________ **Relationship to patient:** ____________________________________