MediCopy

Authorization for the Release of Medical Records from Tennessee Orthopaedic Alliance

TOA

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?

□ All Records □ Office/Clinic Notes □ Operative Reports

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

□ Dates _____ to _____ □ Other _____

□ If requesting imaging, please specify imaging needed: _____

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

Purpose of Disclosure: Why are we sending the records?

□ Personal Use □ Litigation/Legal □ Insurance □ Transferring to New Physician □ Continuation of Care

Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ Pick-up at MediCopy ☐ Mail (postage fees may apply)

MediCopy will always provide medical records via encrypted email or fax. Please note that unencrypted email or faxing are not secure forms of communication and may therefore be at risk of being accessible by unauthorized individuals. By signing below, you are acknowledging that IF you request an unencrypted delivery method you have been made aware of these risks.

Patient's Signature

I hereby authorize MediCopy 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. I understand I can refuse to sign this authorization and my healthcare provider may not condition treatment on my signing this authorization.

Patient's Signature: Date:

Relationship to patient: