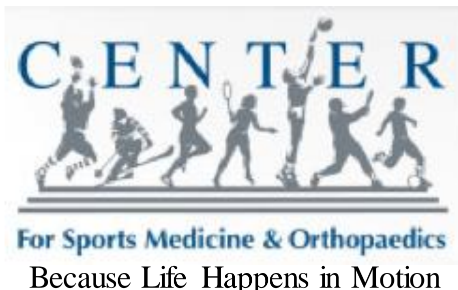
**FORM MUST BE COMPLETED IN FULL OR REQUEST WILL NOT BE FULFILLED**




Because Life Happens in Motion

**Check one box:**

**<u>For Medical Records Copies</u>** **(Fee of $15 per patient request*)**
7480 Ziegler Road, Chattanooga, TN 37421
For Additional Information, please call (423) 697-8759
Fax this form to (423) 697-2059 **Attn:** Release of Information Staff
**This rate is not applicable to requests from third parties.*

**<u>For Forms Processing</u>** **(Fee of $20 per form)**
2415 McCallie Ave, Chattanooga, TN 37404
For Additional Information, please call (423) 697-8840
Fax this form to (423) 664-5156 **Attn:** Forms Specialists Staff

## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

****This request is for documents only. Please notify staff member if you would like to request imaging studies (<u>X-ray & MRI films on disc</u>).**

Preparation time - 7 to 10 Business Days

Patient Name:________________________________Date of Birth:______________________________

Phone #______________________________Work or Cell#____________________________________

Address:_________________________________ City:_________________ State:____ Zip:_______

Date(s) of Service needed: From_____________________________To___________________________

Which provider at Center for Sports Medicine are you requesting records from:______________________

Description of Information Requested: (example: office notes/imaging reports/lab reports)
______________________________________________________________

Email Address (required for electronic delivery) – PERSONAL EMAIL ADDRESS ONLY
___________________________@__________________

Reason for request: ________________________________

**Fill out the following if you want us to release requested records to another person(s) other than to the Patient:**

Name of Company OR Healthcare Provider:
____________________________________________________________

Address:_________________________________ City:_________________ State:____ Zip:________

**<u>Fax Number (Required):</u>** _______- ________ - _________

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective only to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed, pursuant this authorization, may be subject to re-disclosure by the recipient of this disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign the authorization.

Patient Signature:_______________________________________Date Signed:__________________

* Expiration Date is One Year (1) from Date Signed unless otherwise stated:________________________________
* A photocopy or fax of this authorization is as valid as the original.

**FOR OFFICE USE ONLY –SPORT MED Employee:___________________________________**