Center For Sports Medicine
2415 McCallie Avenue
Chattanooga, TN 37404
Please call (423) 697-8840

CENTER FOR
SPORTS MEDICINE
& ORTHOPAEDICS

Fax: (423) 664-5156
Attn: Forms Specialist
* Fee of $20 per form

Release of Information for FMLA/Short Term Disability Documentation

Please allow 7 business days for processing (7-10 business days during the holidays)

AUTHORIZATION AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name: _____ Date of Birth: _____

Phone Number: _____

* DISABILITY COMPANY: _____ Fax Number: _____

* EMPLOYER: _____ Fax Number: _____

Which Provider at Center for Sports Medicine and Orthopaedics are you under the care of?

Dr. _____

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: _____

* Expiration date is one (1) year 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: _____