Tennessee Valley Bone and Joint
2350 North Ocoee St
Cleveland, TN 37311
Phone: 423-476-5554 Fax:423-614-6116

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Important: All sections MUST be completed)

Patient: _____ Birth date: _____

Address: _____City/State_____Zip_____

Social Security#_____ Home#_____Cell #_____

Must Complete:

Please [ ] MAIL or [ ] FAX If fax request please include Fax#_____

The below specified records from_____ to _____.

Address to mail records to _____

_____

_____

Phone#_____ Fax#_____

Specific type of information to be released: [ ] Any/All records [ ] Diagnostic reports [ ] Lab results
[ ] Office Visits [ ] Operative Notes [ ] Other _____

For date range: _____ to _____.
(If no time period specified, records from previous 2 years only will be released)

Purpose of disclosure: [ ] Transfer of Care [ ] Insurance [ ] Worker's Comp [ ] Self [ ] Attorney
[ ] Social Security [ ] 2nd Opinion [ ] Other_____

*I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Office Manager. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire 90 days after the date below.
*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have questions about disclosure of my health information, I can contact the Office Manager at the disclosure location.
*NOTICE TO PERSONS OR ORGANIZATION: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

_____
Signature of Patient or Legal Representative (relationship) Date Signed

_____
Signature of Office Representative Date Signed

For TVBJ Office Use Only

MEDICAL RECORD FEES if applicable:

- TVBJ and/or copying service charges may differ. If our copying service provides records you will be billed separately.
- The fee for all life / accident / disability insurance applications is a minimum of $20.00
- The fee for CD of x-ray is $10.00.

Fee Collected $ Date/Initials