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: ____________________Acct#___________

Address: ____City/State______________________Zip___________

Social Security#______________________ Home#_____________________Alternate #____________________

Must Complete: [ ] **MAIL or** [ ] **FAX** MEDICAL RECORDS [ ] **TO or** [ ] **FROM**

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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 after 90 days after 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 (HIPPA) privacy regulations.

____ ________________________________
Signature of Patient or Legal Representative (relationship) Date Signed

____ ________________________________
Signature of Office Representative Date Signed

For Office Use Only

MEDICAL RECORD FEES (to be paid in full prior to release of information) if applies:

- TVBJ and/or copying service, charges $20 for the first 1-40 pages and .25¢ each additional page thereafter.
- The fee for all life / accident / disability insurance applications, $15 for 1st (2) pages $5 for each additional.
- The fee for CD of x-ray (2008) is $5 and the deposit for original x-ray films is $25.00(refunded upon return).

Based on review of your request, the fee is: ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $ ☐ NO CHG

Fee Collected $________ Date/Initials______________ Circle: Faxed | Mailed | Picked UP

Return this release and remit the fee to: Tennessee Valley Bone and Joint
2350 North Ocoee St
Cleveland, TN 37311