Authorization To Release Medical Records

Records Released From:

Facility / Physician's Name: _____

Patient Information:

Patient Name: _____ DOB: _____ SS#: XXX-XX _____

Address: _____

City, State, Zip Code: _____ Phone: _____

Release Records To: ☐ *Same As Above*

Name: _____

Address: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Information Requested & Purpose of Disclosure:

Specific Categories

- ☐ All Records
- ☐ Office / Clinic Notes
- ☐ Lab / Pathology Results
- ☐ Other _____

Or Dates from _____ to _____

Fee Schedule

Please Note: Typically records sent from physician to physician, are sent free of charge.

Fee Schedule		Delivery Method	
Pages 1-5	$20.00	Fax ☐	Free
Pages 6+	$0.50 / page	Pick-up ☐	
Fees reflect TN statute 63-2-102, revised 06-2010		Records on CD ☐	$7.00

Purpose of Disclosure

☐ Transfer of Care ☐ Personal Use ☐ Litigation/Legal ☐ Disability ☐ Insurance

Patient Signature

I hereby authorize The Pain Management Group and its affiliates to release or disclose to the above-named person(s) or organization 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 twelve (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 cancellation notification. I understand that the information used or disclosed may be subject to re-disclosure by the recipient of this request and will no longer be protected by federal regulations.

Patient Signature: _____ **Date:** _____

Signature of Legal Guardian: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

PAIN MANAGEMENT Group pmg | Advanced HEALTH

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