# Authorization for the Release of Medical Records

## Patient Information

Name: DOB: SSN (last four): XXX-XX-

Email:

Address:

City: State: Zip:

Phone # (include area code): Fax # (include area code):

## Purpose of Disclosure: Why are we sending the records?

☐ Personal Use ☐ Litigation/Legal ☐ Transfer to New Physician

If you do not want certain portions of your medical records released, please check the categories listed below you would like excluded.

☐ Substance Abuse, if any ☐ AIDS/HIV/STDs, if any ☐ Psychological/Psychiatric conditions, if any

## Delivery Method: How would you like the records sent?

☐ Email ☐ Fax ☐ US Postal Service (see below for fees)

Medical records sent via email or fax are at no charge and HIPAA compliant encryption is used. A flat $20 fee will be charged for paper records (any number of pages) mailed through USPS (refer to fees set by Title 63 Professions of the Healing Arts / Chapter 2 Medical Records / 63-2-102 and Tennessee Code Annotated 68-11-304). **If you choose US Postal Service for your delivery method, payment must be received via check or money order <u>BEFORE</u> records will be sent.**

## Where are we sending the records?

Name/Attorney/Physician:

Email:

Address:

City: State: Zip:

Phone # (include area code): Fax # (include area code):

## Signature

I hereby authorize Paul Gorman, MD to release or disclose to the person(s) or organization listed above, 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 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 notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations.

Person making the request: Relationship to Patient:

Signature: Date::

Send to: Paul Gorman, MD ▪ PO Box 6043 ▪ Johnson City, TN 37602
P: 423-282-5332 (until 12/31/19) ▪ F: 423-722-1682 (until 12/31/19)