AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize Knoxville Orthopaedic Clinic and its physicians, employees and agents to release or disclose to myself or the below-named recipient all of my medical records specified.

Patient Name: _____ Date of Birth: _____
SSN: _____-_____-_____

Address: _____ Phone: _____
_____

I hereby authorize the release of medical records to: _____
Address: _____
Fax/Phone: _____

Purpose of disclosure: _____
The authorization will expire on: _____
Date or Event my not exceed one year

Information to be released: _____
_____

Date of service(s): _____ _____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative Date Signed

Relationship to Patient

There will be a fee for copies of medical records and a $25.00 charge for completion of FMLA/Disability forms. Fees will be due prior to records being released. If your Short Term disability company is requesting copies of records a fee for those records may be required. **Please make check or money order payable to Acton Corporation**. Acton Corporation is contracted with Knoxville Orthopaedic Clinic to handle Release of Information and FMLA/Disability Services. ROI Department: Phone: 865.558.4431; FMLA /Disability Office: Last name beginning with A-L 865.558.4409 and Last name beginning with M-Z 865.558.4428. Please fax Completed forms to 865.558.4416