Authorization to Release Medical Records and Information

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Social Security Number: _____

I authorize the release of all of my medical records to Cumberland Pain Associates, PLC for the purpose of further medical care. These records include, but are not limited to, office and operative notes, diagnostic tests, and laboratory results. **Please fax the requested information to (615) 860-2420.**

I understand the following:

1. I may revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
2. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
3. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
4. The information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information unless stated below.
5. Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Printed Name of Patient or Legally Authorized Representative Relationship to Patient

_____ _____

Witness Signature Date

Skyline Medical Plaza
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