Please email completed form to:
status@healthmark-group.com

Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to:

To Recipient:
(Who/Where are the records going)

Person/Company ______________________

Address ______________________

City ______________ State ______________ Zip ______________

Phone ______________ Fax ______________

From Clinic:
(Where are the records coming from)

TMI Sports Medicine and Orthopedic Surgery

Patient Name ______________ Phone/Email ______________ Date of Birth ______________

Dates of Service (Check one):

- ☐ Please provide a complete copy of my file for all dates of service.
- ☐ Please provide a complete copy of my file for service dates from: ______________ through ____________

Records to be realeased: (45 CFR § 164.508(c)(1)(i))

☐ All Medical Records	☐ History & Physical	☐ Consultation Reports
☐ Emergency Room Records	☐ Operative Report	☐ Discharge Summary
☐ Lab/Pathology Reports	☐ Radiology Report	☐ Images
☐ Itemized Billing	☐ Other __________________	

Purpose for Disclosure:

☐ Disability	☐ Insurance	☐ Attorney
☐ Referring Physician	☐ Patient Request	☐ Other ________________

Please indicate your acceptance by checking the following boxes:

- ☐ I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization (45 CFR § 164.508(c)(2)(i)).
- ☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for preemployment purposes (45 CFR § 164.508(c)(2)(ii)).
- ☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I Understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR § 164.508(c)(2)(iii)).

This authorization will expire one hundred eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: ______________________________ **Signature:** ____

Patient or Legally Authorized Representative