State of Franklin HEALTHCARE ASSOCIATES™

Interventional
Pain Management

301 Med Tech Parkway, Suite 110
Johnson City, TN 37604
Phone (423) 794-5580 | Fax (423) 232-8561

Authorization for Release of Medical Information

Patient's Name: _____ Patient's Phone#: _____

Date of Birth: _____ SSN: _____

Address: _____

City/State/Zip Code: _____

____ I authorize SoFHA Interventional Pain Management **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax #

____ I authorize SoFHA Interventional Pain Management **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax #

INFORMATION TO BE RELEASED OR OBTAINED:

___Complete Health Record
___X-Ray Reports
___Progress Notes
___Other (please specify)
___History & Physical Examination
___Laboratory Test
___Photographs, CD's, or other Images
___Consultation Reports
___Discharge Summary

_____

PURPOSE FOR THIS REQUEST:

_____Transfer of Care **_____Healthcare** **_____Insurance Coverage** **_____Personal**

I understand that:

1. My right to healthcare treatment is not conditioned on this authorization.
2. I may cancel this authorization at any time by submitting a written request, except where a disclosure has already has already been made in reliance on my prior authorization.
3. If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
4. Release of HIV-related information, mental health care, or substance abuse diagnosis and treatment information requires additional authorization.
5. This authorization will be valid for one year from the signature date OR _____

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient or Representative: _____ **Date:** _____

Relationship to Patient (if requester is not the patient**):** _____

Signature of Witness: _____ **Date:** _____