satellitemed

# AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: Patient Date of Birth:

As the:

❑ Above Named Patient
❑ Parent or Legal Guardian of the above named patient
❑ Legal Representative of the above name patient
❑ Other _____

I am requesting the following information be: ❑ Sent to Satellite Med ❑ Released by Satellite Med

| For Health Information **BEING SENT to Satellite Med** please use the following information. | **Please complete the information on where to send/request your Health Information** |
|---|---|
| **Satellite Med** | Name Party: |
| **1120 Sam's Street**<br>**Cookeville, TN 38506** | Address: |
| Ph: **931-528-7312** Fax: **931-528-7377** | Ph: Fax: |
| Email: | Email: |

***Records can be made available via secure email***

***Check all that apply***

| | | | |
|---|---|---|---|
| ❑ Complete Records | ❑ Lab Reports | ❑ Pathology Reports | ❑ Care plan |
| ❑ History & Physical | ❑ Operative Reports | ❑ Hospital Reports | ❑ Treatment Plan |
| ❑ Medication Records | ❑ Radiology Reports | ❑ Progress Notes | ❑ Other _____ |

Purpose of Disclosure:

This authorization expires on _____ The date may not exceed 1 year from date signed and may be revoked at any time prior to the expiration of the authorization.

I have the right to limit certain parts of my records from release and choose not to have the following included in the release of information. ***Check all that apply***

❑ Substance Abuse ❑Psychological/Psychiatric Treatment ❑ HIV/STD/AIDS

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 the potential for an unauthorized re-disclosure which may not be protected by the 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. By signing this form, I authorize the above mentioned to release confidential Health information about me, by releasing a copy of my medical records to the physician/facility/person/entity listed above. **Satellite Med will be happy to comply with your request; however we have a charge of $20.00 for the processing of those records by fax or secure email only. If you wish to have records mailed, our fee is $20.00 for the first 5 pages and $0.50 per page after the first 5 and the actual cost of mailing (under T.C.A. section 63-2-102). There is no charge to send directly to the physician or for continuation of care.**

_____ _____
Signature of patient or Authorized Representative Date

_____ _____
Patient Date of Birth Patient SS#

_____ _____
Witness Signature Date