Dear Patient:

Thank you for contacting Tennessee Orthopaedic Alliance East Tennessee Medical Records Department. To better serve you with your request for medical records, Tennessee Orthopaedic Alliance East Tennessee has partnered with MedRecs Management.

MedRecs Management will fulfill your request for records in a safe, secure, and timely manner. The quickest way (typically less than 3 days) for you to receive a copy of your records is to visit our website, tocdocs.com. Under the Patient Resources tab, you will see Request Medical Records. After clicking this tab, you will be directed to a page with information on obtaining your medical records. Click the "Click Here to Request a Copy of Your Medical Records" button and follow the instructions to complete your request.

If you cannot complete the request via the processing page, you will need to complete and return the attached Authorization form. Please make sure you have specific instructions included as to what records you are requesting and where you are requesting your records be sent. You also have a choice of how you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. NOTE: if you choose to have the records mailed to you, postage costs will be added and the process can take up to two weeks.

For records to be delivered to another doctor, please choose fax or mail (select only one option). The fax delivery option may only be used for records going to a doctor. Please mail/fax/drop-off the completed Authorization form to the Tennessee Orthopaedic Alliance East Tennessee location you utilize. For Records being sent to Another Health Care Provider, please provide as much contact information for your other Doctor, including the address, phone number or fax.

You can contact a MedRecs Management representative Monday-Friday 9am-6pm Eastern Time by calling: 865-505-7337 or email at: medicalrecords@medrecsmanagement.com

Thank you,
Medical Records Supervisor
Tennessee Orthopaedic Alliance East Tennessee

Authorization to Disclose Protected Health Information

The undersigned authorizes

to release my health information as noted below:

- ☐ Ft Sanders Regional ▪ 1819 Clinch Ave, Ste. 100 ▪ Knoxville, TN 37916 ▪ Fx. 865-673-8007
- ☐ Oak Ridge ▪ 988 Oak Ridge Tnpk, Ste 100 ▪ Oak Ridge, TN 37830 ▪ Fx. 865-483-4194
- ☐ Oak Ridge Urgent Care ▪ 961 Oak Ridge Tnpk ▪ Oak Ridge, TN 37830 ▪ Fx. 865-483-3807
- ☐ Parkwest ▪ 9430 Parkwest Blvd, Ste. 130 ▪ Knoxville, TN 37923 ▪ Fx. 865-560-8559
- ☐ Sevierville ▪ 1679 Veterans Boulevard ▪ Sevierville, TN 37862 ▪ Fx. 865-673-8007
- ☐ Lenoir City ▪ 576 Ft Loudon Med Cntr Dr ▪ Lenoir City, TN 37771 ▪ Fx. 865-988-8837
- ☐ Bearden ▪ 6484 Kingston Pike ▪ Knoxville, TN 37919 ▪ Fx. 865-673-8007
- ☐ Fountain City ▪ 4882 Harvest Mill Way ▪ Knoxville, TN 37918 ▪ Fx. 865-381-1206
- ☐ Alcoa ▪ 1146 Franck Street ▪ Knoxville, TN 37701 ▪ Fx. 865-324-5973

Patient Information

Patient Full Name: ___________________________________ **Other Names?** __________________________

Patient Address: ____ **Date of Birth:** _______________________

City: _______________________ State: ______ Zip: ___________ Phone #: __________________________

Release Information To

Name/Facility: ____ **Attention:** __________________________

Address: ____ **Phone:** _____________________________

City: _____________________ State: ______ Zip: ________ **Fax #:** __________________________

Email: ____ *(Please ensure email address is legible!)*

Purpose of Request: ☐ Treatment ☐ Transfer ☐ Other:____________

Please forward Records by: ☐ Mail ☐ Fax *(for Dr's Offices)* ☐ Email

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **2 year abstract** of my records

Abstract includes most notes, labs, procedures & testing

☐ Please release a **5 year abstract** of my records __________

☐ **Date Range**: ______________________________

☐ Progress Notes ☐ Radiology Reports ☐ Labs

☐ Operative Reports ☐ Physical Therapy Notes

☐ Other: _________________

Pursuant to HIPAA 45 CFR, 164.524, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies. If you want the entire medical record, the rate will increase proportionally based on the cost. At no time will the cost-based fees exceed Tennessee State law: Statute 63-2-102.

Records being sent to another healthcare provider will be sent at no cost.

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Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* __________ (*Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ______________________________. *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_______________________________________ **Date:** _______________

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*