Satellite Med®

Providing access to quality, affordable healthcare

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 of Hospital or Health Clinic:
1120 Sam's Street **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