OBTAIN

Total Sports and Family Care
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Karen L. Allen, M.D. **Darla R. Cowart, M.D.** **Brian A. Cost, M.D.** **Jeff Garrard, M.D.**

Authorization to Release Protected Health Information

Patient's Name:_____ Date of Birth: _____

Address: _____

City/State/Zip Code: _____

SS# _____ Patient's Phone #:_____

Date of Request:_____ Date information needed:_____

The undersigned patient hereby authorizes the employees of:

_____
Name of Disclosing Provider or Facility

_____
Address

_____
City, State, Zip Code Phone Fax

to release my protected health information identified below to employees of each of the following entities:

Total Sports Care, P.C. Brian A. Cost, M.D., P.C. Jeff Garrard, M.D., P.C.

Purpose for this Request:

☐ Transferring Care ☐ Personal - Not Transferring Care
☐ Work Related ☐ Insurance Coverage
☐ Other: _____

_____

Type of Records Requested: (check one)

☐ Specific Information (select one, or more, as applicable)

☐ Consult ☐ Laboratory Test Results ☐ X-Ray Reports
☐ Discharge & Summary ☐ Office Notes
☐ History & Physical ☐ Operative Report
☐ Other: _____

_____

☐ All Medical Records related to a specific illness or injury:

Specific illness / injury: _____ Date(s) of Treatment: _____

☐ All Medical Records:

Specific Description of Records:_____

_____

- I understand that I may change my mind and revoke this Authorization at any time in writing, except to the extent the releasing party has already relied upon this Authorization.
- I understand that protected health information disclosed based on this Authorization may be redisclosed by the receiving person or entity and may no longer be protected from disclosure to others by federal or state law.
- I understand that protected health information disclosed based on this Authorization may include mental health treatment, alcohol or drug abuse treatment and/or sexual health treatment including HIV/AIDS related information. I authorize release of all medical information concerning these diagnoses and/or treatment of these conditions, to the extent included in the records identified above.
- I understand that neither Total Sports Care, P.C., Brian A. Cost, M.D., P.C., Jeff Garrard, M.D., P.C. nor the releasing party may condition my treatment on my execution of this Authorization to Obtain Protected Health Information.
- I understand that this Authorization expires one year from the date of signature, or the following earlier date_____.
- I acknowledge that the party releasing my records will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

_____ _____

Signature of Patient or Guardian Date

Signature Page to
Authorization to Release Protected Health Information

NOTE TO RELEASING ENTITY: This release is provided as a courtesy by Total Sports Care, P.C., Brian A. Cost, M.D., P.C. and Jeff Garrard, M.D., P.C. Total Sports Care, P.C., Brian A. Cost, M.D., P.C. and Jeff Garrard, M.D., P.C. and their individual employees, shareholders, officers and directors make no representations or warranties whatsoever with regard to this release, your use of this release, the adequacy of this release under any applicable law, or the sufficiency of this release to protect your interests. The releasing entity hereby assumes all risks arising from the use of this release.