



I, _____ authorized Ford Center for Anti-Aging and Pain Management to release the
(Please Print) following protected health information:

- Office Visits Dates: _____
- Financial Statements: _____
- Procedure Reports: _____
- Hormone Levels or lab work: _____
- Drug Screen results: _____
- X-Rays, SNCS or other radiology: _____
- Other: _____

I authorize Ford Center for anti-Aging and Pain Management to release the above information to:

- Self.** I understand that in accordance with State law **63-2-102**, I will pay twenty dollars (\$20.00) for medical records five (5) pages or less in length and fifty(50)cents per page for each page copied after the first five pages. I understand that these records will be made available only after payment has been received and may take up to ten (10) business days to complete.
- Case Manager / Other Physician.** I understand that these records may include demographical information, mental health records and/or drug screen results. I understand that without providing the correct contact information, my request cannot be completed. It is my responsibility to provide the correct contact information.

Please forward my records to Dr.: _____

Address / Faxnumber: _____

- Attorney / Disability Representative.** I understand that these records may include demographical information, mental health records and/or drug screen results. I understand that without providing the correct contact information, my request cannot be completed. I understand that without a written request from my attorney\disability representative stating that they will cover the cost of these records, I will pay \$20.00 for medical records five (5) pages or less in length and fifty (50) cents per each page for each copied after the first five pages. I understand that these records will not be faxed and WILL ONLY BE MAILED after payment has been received. I understand this request may take up to ten (10) business days to complete

Attorney Name & Address

Patient Signature, SSN & Date: _____

Witness Signature & Date: _____

This release will expire automatically one year the date signed above. I understand that I may revoke this authorization in writing at any time. This revocation will not apply to information that has already been released via this authorization.

Ford Center for Pain Management and Anti-Aging
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