Vaughn Orthopedic & Spine Center, PLLC. (hereafter known as VOS)
935 Spring Creek Road, Suite 200
Chattanooga, TN 37412
Phone: (23) 664-4787 Fax: (423) 664-4784

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth: _____

I hereby authorize_____Fax#_____release

my Protected Health Information to: _____Vaughn Orthopedic & Spine_____

Please send information via: __Fax ___Mail __I will pick up in the office

Mailing Address or Fax Number:___423-664-4784_____

_____

Information to be used and disclosed:

___Office notes and/or RTW note dated:_____
__Entire medical chart
___Claims/Billing Information
___Radiological Reports and/or Films
___Electromyography/NCS
___Lab Results
___Hospital Records
Other_____

For the Purpose of: _X_At my request ___Worker's Compensation ___Insurance Company

- I understand that, as set forth in VOS's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to Vaughn Orthopedic & Spine Center, 935 Spring Creek Road, Suite 200, Chattanooga, Tennessee 37412 ATTN: Office Manager.
- I understand that revocation is not effective to the extent that VOS has relied on the use or disclosure of the Protected Health Information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that VOS will not condition treatment on whether I provide authorization for the requested use or disclosure.
- I understand I have the right to inspect or copy my Protected Health Information to be used or disclosed as permitted under federal law. I also understand that I have the right to refuse to sign this authorization.
- This Authorization will expire on 3 months from the date of signing this document.

_____Date_____
Signature of Patient or Personal Representative

As a personal representative, I have authority to act for the individual because I am:_____
(Copy of legal documents must be furnished to VOS upon request).

_____Date_____
Signature of Worker's Compensation Case Manager

_____Copy of this authorization given to the patient or personal representative

_____Letter of any reproduction costs given to the patient or personal representative

_____Date Completed _____By