Dennis C. Ford, M.D.
American Board of Pain Medicine
American Board of Anesthesiology
American Board of Family Medicine
American Board of Anti-Aging

Sarah Ford, NP-C

Release of Information

I, ______________________________, authorize Ford Center for Anti-Aging and Pain Management to release the following health information:

Office Visits	Procedure records	Financial statements	X-ray reports, MRI's, CT reports, ect.
Drug screen results	Hormone level or lab work	Other (specify): ______________________	

I am requesting information for:

☐ **Self.** I understand that I will pay a processing fee of $20.00 **for the first five pages and $0.50 for each additional** page. I will **only receive records that are requested from above,** and without this information, my request may not be completed. These records will be available for me to pick up three (3) business days **after** the submission of this request during normal business hours (7:00 am to 11:00 am) to (12:00 pm to 3:00 pm). **If I do not retrieve** these records **within thirty (30) days, the copies will be destroyed.**

☐ **Continuation of care.** I understand records that are sent for continuation of care may include demographical information, mental health records, and UDS results. I understand that **without this contact information,** my **request cannot be completed.** These records are **free of charge to this M.D.**
Please forward my records to Dr. ____________________.
Address: ____
Phone number: (________) ____________-____________Fax: (________) ____________-____________

☐ **Attorney.** I understand records sent for attorneys may include demographical information, UDS results, and mental health records. I understand that **without this contact information, my request cannot be completed.** The attorney to whom these records are delivered **may or may not be responsible for remitting payment** according to the Tennessee Code annotated guideline. **(Note: Before records will be sent to attorney's office, we will need a statement from the attorney on the attorney's letterhead stating they will pay for these records. If not, I understand that I will be responsible for payment.)**
Name: ____
Address: ____
Phone number: (________) ____________-____________Fax: (________) ____________-____________

☐ **Other:** I understand that I may be required to pay for these records, if the party receiving the records denies payment. I understand that records sent may include demographical information, mental health records, and UDS results. I understand that **without this contact information, my request cannot be completed.**
Name: ____
Address: ____
Phone number: (________) ____________-____________Fax: (________) ____________-____________

This release will expire automatically one year from the date signed below. 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 on this authorization.

______________________________ ______________________________
Patient Signature Date of Signature

______________________________ ______________________________ ______________________________
Witness signature & Date Patient SSN Patient DOB