Covenant HEALTH

ACCOUNT NUMBER/S: _____

□CLMC □CMC □CMG □FLMC □FSRMC □LMC □MHHS □MMC □PMC □PMMH □RMC □TCSC □Home Care

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _____authorize_____(Provider/s) to disclose health information as instructed below.

1. Patient Name: _____Date of Birth: ___/___/_____Social Security Number:_____-____-_____

The information is to be disclosed to the following persons or organizations: (If for **self**, address must be completed.)
Name: _____ Phone:_____ Fax:_____
Address:_____City:_____State:_____Zip_____

2. Purpose:_____

3. The information to be disclosed includes those items checked below, from dates _____to_____. I understand that this information may include, but not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, treatment for drug and/or alcohol use.

☐ Entire medical record, other than psychotherapy notes*

OR

□ Discharge Summary	□ Progress Notes	**OTHER**:
□ History and Physical Exam	□ EKG/s	
□ Consultation Report/s	□ Photographs, videotapes, or other image	
□ Operative Report	□ HIV Test Results and Treatment	
□ Pathology Report	□ Mental or Behavioral Health	
□ Emergency Room Record	□ Physical/Occupational/Speech Therapy	
□ Lab Results	□ Cardiac Rehabilitation	
□ Radiology Report/s	□ Psychotherapy Notes*	

***** If the authorization is for psychotherapy notes, it may not request any other part of the medical record.

I understand that there will be a reasonable fee for these copies according to Tennessee State Law and Federal Guidelines.

4. Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received.

5. Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: 1) One year after the date this authorization is signed **or** 2) On the occurrence of the following event:_____.

6. Redisclosure: I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. Refusal to Sign: I understand that I may refuse to sign this Authorization and that the Provider will not condition treatment on whether I sign this Authorization.

8. I certify that I am (check whichever applies):
- ☐ the patient, and the identification that I have provided is true and correct.
- ☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.
  My relationship to the patient is that of _____. (Must provide legal documentation.)
  List reason if patient is unable to sign_____.

SIGNATURE: _____ **DATE**_____/_____/_____**TIME**_____

FOR PROVIDER USE ONLY

How was identity verified?_____ Copy made? ☐ Yes ☐ No
How was authority verified? _____ Copy made? ☐ Yes ☐ No
By: _____Title: _____Date: _____