

DT159801

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**AUTHORIZATION FOR DISCLOSURE
OF PROTECTED HEALTH
INFORMATION**

Patient Identification

I, _____, (DOB: _____)

SS#: _____) hereby authorize Memorial Health Care System (MHCS) to use and/or disclose my individually identifiable health information as described below:

I authorize the following person(s) or organization to release or receive the information:

Name: _____

Street Address: _____

City, State and Zip

Code: _____

The following individually identifiable health information may be used and/or disclosed:

Check all that apply:

Discharge Summary

Reports of Tests & X-rays

Inpatient Records

Face Sheets with Final Diagnosis,

Emergency Room Record

Outpatient Records

Complications and Procedures

Consultation Reports

Abstracts

History and Physical Records

Immunization (shot) Record

Physical Therapy Notes

Outpatient Clinic Notes

Other*: _____

*If authorization is for marketing, indicate if MHCS will receive compensation in exchange for the use and/or disclosure of the PHI. Yes No

Dates of treatment to be released: _____

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological condition, psychiatric/mental health treatment and/or HIV-related conditions.

Reason or purpose for the use and/or disclosure of the information:

Prohibition on Conditioning of Authorization: MHCS will not condition treatment on your signing this authorization, unless:

- You are receiving research-related treatment; or
- The only reason the facility is providing you with health care is to make a report to a third party, such as your employer (i.e., fitness to return to work) or school (i.e., P.E. physical).

Redisclosure: I understand that the information used and/or disclosed according to this authorization may no longer be protected by federal privacy law (also known as HIPAA) and the recipient of your health information may potentially redisclose it. However, under the Federal Substance Abuse Confidentiality Requirements, 42 CFR Part 2, the recipient may be prohibited from disclosing identifiable substance abuse information.

Expiration: This authorization will expire _____ (no longer than 90 days past requested date or once purpose stated above is served).

Memorial Health Care System

2525 deSales Avenue Chattanooga, TN 37404
2051 Hamill Road Hixson, TN 37343

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Revocation: I understand that I may revoke this authorization at any time by notifying MHCS in writing by sending a letter to Health Information Services, 2525 deSales Ave., Chattanooga, TN 37404, or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that MHCS took before it received my revocation letter. For example, MHCS cannot rescind disclosures it has already made and may use my health information as necessary to bill and collect for services rendered.

This Authorization is binding: The statements made in this authorization are binding and controlling, and I understand that they take precedence over statements made in MHCS's Notice of Privacy Practices.

Signature of Individual or Personal Representative

Date

Printed name of individual's personal representative, if applicable: _____

Rationale for serving as personal representative to the individual (i.e., parent, legal guardian):

**This form may be faxed to MHCS Health Information Services at: 423-495-4740
Phone: 423-495-8285**

FOR INTERNAL PURPOSES ONLY

When MHCS is requesting an authorization to use health information for its own use, the following provision must be completed:

Staff Personnel:

Received by: _____

Date

Was a signed copy provided to the individual? Yes No