CHI Memorial
Imagine better health.℠

159801

Patient Identification

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Medical Record Number: _____ **Date of Birth:**_____

Patient Name:_____ **Last 4 of Social Security #**_____

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Home Phone:_____ **Work Phone:**_____

1. RECEIVING PARTY:

Please release my health information to:

Name:_____

Address:_____

City:_____ State:_____ Zip Code:_____

*Fax Number (*for medical purposes only - emergent or in office): _____

2. DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:

☐ Complete medical record (***Please specify dates of service)***_____
-OR-
☐ Partial medical record (***Please specify sections needed below)***

Information	Dates	Information	Dates
☐ Operative Reports	_____	☐ Images/CDs	_____
☐ History & Physical.....	_____	☐ Imaging Reports	_____
☐ Discharge Summary ...	_____	☐ Pathology Slides	_____
☐ Face Sheet	_____	☐ Pathology Reports	_____
☐ Consultations	_____	☐ Echocardiogram Reports	_____
☐ Sleep Center Reports .	_____	☐ EKG Reports	_____
☐ Emergency Room Reports	_____	☐ EEG Reports	_____
☐ Surgical Photographs .	_____	☐ PFT Reports	_____
☐ Cardiac Cath Imaging..	_____		

☐ Other*(***Please specify content and dates of service)***:_____

*If authorization is for *marketing*, please indicate if Memorial Health Care System (MHCS) will receive compensation in exchange for the use and/or disclosure of the PHI. ☐ Yes ☐ No

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**.**

3. REASON OR PURPOSE FOR THE USE AND/OR DISCLOSURE OF THE INFORMATION:

_____

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4. EXPIRATION OF AUTHORIZATION

Unless I request in writing otherwise, I understand that this authorization will expire on _____ *(insert appropriate date or event)*. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed the authorization.

5. RIGHT TO REVOKE AUTHORIZATION

I understand that I have a right to revoke this authorization at any time by notifying Memorial Health Care System (MHCS) in writing by sending a letter to Health Information Services, 2525 deSales Avenue, Chattanooga, TN 37404, or by 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.

6. RE-DISCLOSURE

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

7. FEES

I understand that federal and state laws allow a fee to be charged for the copying of patient records, and I will be responsible for the payment of such fees. (*This facility has contracted with HealthPort to make copies. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.)*

8. REFUSAL TO AUTHORIZE USE AND /OR DISCLOSURE

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that MHCS may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information for such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as workers compensation examination).

_____ _____

Signature of Patient (or Patient's Personal Representative) Date

_____

Printed Name of Patient's Personal Representative, if applicable

_____

Description of Personal Representative's Authority to Act for Patient
(e.g., parent, legal guardian, healthcare power of attorney)

NOTE: A COPY OF THIS COMPLETED, SIGNED AND DATED FORM WILL BE PROVIDED TO THE PATIENT AND/OR THE PATIENT'S REPRESENTATIVE ON REQUEST, AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD.