



Authorization For Use or Disclosure of Protected



Health Information/Access to Protected Health

I, \_\_\_\_\_, [Print Name of Individual (i.e., patient, resident, or client)] hereby authorize \_\_\_\_\_ [Insert Record Owner] to use and/or disclose the individually identifiable health information as described below for the following patient:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

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

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

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

Check (✓) all that apply:

- \_\_\_ All Records \_\_\_ Outpatient Clinic Notes
\_\_\_ Discharge Summary \_\_\_ Reports of Tests & X-rays
\_\_\_ Inpatient Records \_\_\_ Facesheets with Final Diagnosis
\_\_\_ Emergency Room Records \_\_\_ Outpatient Records
\_\_\_ Complications, and Procedures \_\_\_ Consultation Reports
\_\_\_ Abstracts \_\_\_ History and Physical Records
\_\_\_ Immunization (shot) Record \_\_\_ Physical Therapy Notes
\_\_\_ Other\*: \_\_\_\_\_

\* If authorization is for marketing, indicate if CHI Memorial Medical Group will receive compensation in exchange for the use and/or disclosure of the PHI. \_\_\_ YES or \_\_\_ NO

Dates of treatment to be released: \_\_\_\_\_

I request the form of the information be \_\_\_ Paper \_\_\_ Electronic (CD/DVD) \_\_\_ Electronic (Email)

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.



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

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I understand a fee may be charged for copies of my medical record.

**Prohibition on Conditioning of Authorization:** CHI Memorial Medical Group 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 (e.g., fitness to return to work) or school (e.g., P.E. physical).

**Re-disclosure:** 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 re-disclose 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 in one year from the date it is signed.

**Revocation:** I understand that I may revoke this authorization at any time by notifying CHI Memorial Medical Group, 5600 Brainerd Road, Ste. 500, Chattanooga, TN 37411, Attention Medical Records Department in writing by sending a letter to the CHI Entity specified on this release or completing the Revocation of Authorization form. I understand that if I revoke this authorization, it will not affect any actions that CHI Memorial Medical Group took before it received my revocation letter. For example, CHI Memorial Medical Group 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, controlling and I understand that they take precedence over statements made in the CHI Memorial Medical Group’s Notice of Privacy Practices.

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SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE	DATE
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Printed name of individual’s personal representative, if applicable:

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



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***FOR INTERNAL PURPOSES ONLY***

When **[Insert CHI Entity]** 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

Access approved?     YES                                     NO