Request Received: Date:____________Time:____________ MR# or Acct#____________________

AUTHORIZATION AND REQUEST FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

TO:
Medical Records
Cookeville Regional Medical Center ("CRMC")
1 Medical Center Boulevard
Cookeville, TN 38501
Phone: 931-783-2625; Fax: 931-783-2627

Patient's Full Name:__________________________________

Date of Birth: _______/_________/________________

Social Security No (not required):________-_______-________

Person/Organization Requesting Release of Information:

☐ Patient
☐ Physician, Hospital or Other Health Care Provider
☐ Patient's Attorney
☐ Patient's Personal Representative** *(See note on last page.)*
☐ Health Plan or Insurance Company
☐ Other: Specify_________________________________

Specific Person(s)/Organization(s) or Class of Persons Authorized to Receive the Information:

____

*(Note: If information is to be **picked up** by someone other than the person authorized to sign, **this person must be named above**, and **positive identification is required** at the time of pick-up.)*

Address *(If Information is to be Mailed)*: ____
____
____

Email Address (If information is to be accessed by web-based access known as my CRMC Health):______________________________@_________________________

<u>*NOTE</u>: Due to risks associated with faxing confidential health information, CRMC **limits faxing** to special circumstances, <u>such as</u> patient care emergencies and the sharing of authorized information with physicians and other health care professionals <u>with whom we have an organized health care arrangement</u>. If this request meets CRMC's criteria, and **<u>you authorize CRMC to fax information</u>** to the person/organization above, then **write the fax number here**.

Fax Number (If Information is Able to be Faxed): (_____________)____

Purpose of Disclosure:

☐ Treatment by Another Health Care Provider
☐ Lawyer/Attorney Use
☐ Worker's Compensation Claim
☐ Payment or Review by Insurance
☐ Research
☐ Disability Claim
☐ Marketing

(If this authorization is at the request of a "covered entity" for marketing purposes, the provider must state if they ☐ will or ☐ will not receive direct or indirect compensation for the use or disclosure of this information.)

☐ At the Request of the Individual

(This is a sufficient description of the purpose when the <u>patient initiates</u> the authorization and elects not to provide a statement of the purpose.)

☐ Other:____

Please Describe the Information to be Released (Mark all that apply):

Medical Records:	☐ Discharge Summary ☐ History & Physical ☐ Consultations ☐ Operative Reports	☐ Abstract of Key Reports ☐ Laboratory Reports ☐ X-Ray/Imaging Reports ☐ Complete Acute Care Chart	☐ Imaging Films/Studies ☐ Other:_____________ _____________________ _____________________
Billing Records:	☐ Detail Bill/Itemized Statement ☐ Copy of Statement		☐ Other:_____________
Other Records:	☐ **Home Health Care Records**; specify:____________________ ☐ **Cancer Center Records**; specify:____________________ ☐ **Occupational Health Records;** specify:____________________		

For the Following Date(s) of Service:____

When Information is Needed: ☐ As Soon as Possible ☐ By a Specific Date:_____/____/______

(This information is gathered to prioritize requests and attempt to meet customer needs. It does not guarantee that CRMC can meet all requested timeframes.)

This Authorization Will Expire On*: _____/_____/_______ or Upon: ______________________________
Date Specific Event

If not indicated above, this authorization will expire 60 days from the date of signature below.

I authorize Cookeville Regional Medical Center ("CRMC") to release my confidential health information as described above. I understand that I have a right to inspect or obtain a copy of my health information as permitted under state or federal law. I understand that the specific information to be disclosed **may** include testing or treatment for drug or alcohol abuse, mental health, Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), if applicable.

I understand that information disclosed has the potential for **re-disclosure by the recipient** and may no longer be protected by federal privacy regulations.

I understand that I have the right to **revoke** this authorization, **in writing**, at any time by sending such written notification to the **Privacy Officer** at CRMC. I understand that revoking this authorization stops any further disclosures, but cannot undo any disclosures that have already occurred as requested in the original authorization.

I may refuse to sign this authorization. CRMC may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for this requested use or disclosure, unless it is required in order to participate in research-related treatment.

I understand that CRMC may charge a reasonable fee for the supplies, labor and postage involved in copying and mailing this information, unless otherwise limited by law. CRMC will either notify you or send an invoice if there is an associated fee.

X____ **Current Date**: _____/_____/_____

PATIENT SIGNATURE (or Personal Representative**)

****NOTE**: If the patient is represented by another person, please include a description of your legal authority to act for the individual and (if applicable) attach a copy of the proof of legal representation. For example, a Durable Power of Attorney for Health Care is sufficient if the patient is unable to make their own health care decisions. A Power of Attorney for managing finances only authorizes the representative to obtain billing/payment records.

If Patient is Unable to Sign, State Reason:____

Relationship to Patient: ☐ Self ☐ Other:______________________________________

If the CRMC staff need more information to process this request or need to contact you regarding fees, how may we contact you?

Daytime Phone #:_________________________ Other Means:_____________________________

---For CRMC Use Only---

Identification: ☐ Driver's License #___________________________ State:__________
☐ Other, specify:______________________________

Release Completed by:_________________________Date:________________________

If a covered entity seeks an authorization from an individual for a use or disclosure of protected health information, the covered entity must provide the individual with a copy of the signed authorization

Initial here if a copy of this signed authorization has already been provided or obtained by the individual:________