

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): _____ @ _____

***NOTE:** Due to risks associated with faxing confidential health information, CRMC **limits faxing** to special circumstances, such as patient care emergencies and the sharing of authorized information with physicians and other health care professionals with whom we have an organized health care arrangement. If this request meets CRMC's criteria, and **you authorize CRMC to fax information** 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
- Marketing
- Payment or Review by Insurance
- Research
- Disability Claim

(If this authorization is at the request of a "covered entity" for marketing purposes, the provider must state if they will or will not

At the Request of the Individual *(This is a sufficient description of the purpose when the patient initiates the authorization and elects not to*
 Other: _____

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

- | | | | |
|------------------|---|--|--|
| Medical Records: | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Abstract of Key Reports | <input type="checkbox"/> Imaging Films/Studies |
| | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Consultations | <input type="checkbox"/> X-Ray/Imaging Reports | _____ |
| | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Complete Acute Care Chart | _____ |

Billing Records:	<input type="checkbox"/> Detail Bill/Itemized Statement <input type="checkbox"/> Copy of Statement	<input type="checkbox"/> Other: _____
Other Records:	<input type="checkbox"/> Home Health Care Records ; specify: _____ <input type="checkbox"/> Cancer Center Records ; specify: _____ <input type="checkbox"/> 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: _____