EAST TENNESSEE Children's Hospital

ACCOUNT #: _____

ROI#: _____

OFFICE USE ONLY

Fax #:_____ Email: _____

Authorization for Release of Protected Health Information

I hereby authorize East Tennessee Children's Hospital to use and disclose the protected health information from the record of:

Patient name:_____ MR number: _____
(Last) (First) (Middle)

Date of birth:_____/_____/_____ Social security number:_____-_____-_____ Phone number: _____

Street address: _____City: _____State:_____ ZIP:_____

Purpose for disclosure: _____

Release records to the following: **(check one)** Person: _____ Practice: _____ Organization: _____

Group or organization name:_____

Name:_____ Phone number: _____
(Last) (First) (Middle)

Street address: _____

City:_____ State:_____ ZIP: _____

Select the portion of the record to be released, identify all that apply and **please include the approximate date of service:**

✓		Date	✓		Date	✓		Date
	Inpatient Records			Emergency Record			Physician Progress Notes & Orders	
	Outpatient Records			Clinic Records			Psychiatric Evaluation	
	History & Physical			Lab Results			Radiology Results	
	Discharge Summary			Consult			Medical Record	
	Operative Report			Pathology			Other (specify):	

I understand the following:

- That the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.
- In the case of non-custodial status, the name and address of the patient's location/guardian will not be released.
- I may refuse to sign this authorization and refusal will not affect treatment, payment, enrollment or eligibility for benefits.
- That the release of my health records will be for the purpose stated on this form, and only those items checked off will be released.
- That the health record released from East Tennessee Children's Hospital may possibly be re-disclosed by the facility/ individual that receives the record(s) and therefore such information may not be protected under federal confidentiality rules.
- That this authorization is in effect for 180 days from the date of the signature, unless a specific time frame is documented; however, no time frame specified shall go beyond one year from the date of signature.
- That this authorization is not valid for dates of service beyond the date of the signature and that the authorization is valid for a single occasion of release of protected health information and is not valid for recurring requests.
- That I have the right to revoke this Authorization form at any time by sending a written request to East Tennessee Children's Hospital Health Information Management, P.O. Box 15010, Knoxville, TN 37901.
- That my decision to revoke this Authorization does not apply to any release of my health record(s) that may have taken place prior to the date of my request to revoke the authorization.
- That the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- That I am entitled to a copy of this completed authorization form.

_____ _____

Signature of patient or legal representative Date

_____ _____

Relationship to patient Signature of witness