



## 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
<input type="checkbox"/> Operative Reports .....	_____	<input type="checkbox"/> Images/CDs	_____
<input type="checkbox"/> History & Physical.....	_____	<input type="checkbox"/> Imaging Reports	_____
<input type="checkbox"/> Discharge Summary ...	_____	<input type="checkbox"/> Pathology Slides	_____
<input type="checkbox"/> Face Sheet .....	_____	<input type="checkbox"/> Pathology Reports	_____
<input type="checkbox"/> Consultations .....	_____	<input type="checkbox"/> Echocardiogram Reports	_____
<input type="checkbox"/> Sleep Center Reports .	_____	<input type="checkbox"/> EKG Reports	_____
<input type="checkbox"/> Emergency Room Reports	_____	<input type="checkbox"/> EEG Reports	_____
<input type="checkbox"/> Surgical Photographs .	_____	<input type="checkbox"/> PFT Reports	_____
<input type="checkbox"/> Cardiac Cath Imaging..	_____		
<input type="checkbox"/> Other* ( <i>Please specify content and dates of service</i> ): _____			

\*If authorization is for *marketing*, please indicate if CHI Memorial 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 CHI Memorial 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 CHI Memorial took before it received my revocation letter. For example, CHI Memorial  
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 CHI Memorial 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.

**IMPORTANT NOTICE:** The information contained in this facsimile transmission is for the sole use of the intended recipients and may contain  
information that is privileged, confidential and exempt from disclosure under applicable law. If you have received this transmission in error, you are  
hereby notified that we do not consent to any reading, dissemination, distribution or copying of this transmission.

If you have received this transmission in error, please notify CHI Memorial HIM Department at 423-495-8285 or immediately return the facsimile  
documents to the below address. Thank you for your cooperation.

CHI Memorial, HIM Department, 2525 deSales Ave, Chattanooga, Tennessee 37404 (423) 495-8285