Authorization For Use or Disclosure of Protected

Health Information/Access to Protected Health

I, _____, hereby authorize _____ 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
__ Discharge Summary
__ Inpatient Records
__ Emergency Room Records
__ Complications, and Procedures
__ Abstracts
__ Immunization (shot) Record
__ Outpatient Clinic Notes
__ Reports of Tests & X-rays
__ Facesheets with Final Diagnosis
__ Outpatient Records
__ Consultation Reports
__ History and Physical Records
__ 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.

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.

_____

SIGNATURE OF INDIVIDUAL OR PERSONAL REPRESENTATIVE DATE

Printed name of individual's personal representative, if applicable:

_____

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