

AUTHORIZATION TO RELEASE INFORMATION

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Date of Birth: _____ Telephone No.: _____

Trousdale Medical Center
Health Information Management/ROI
500 Church St. Hartsville TN 37074
(615)328.6623 - phone
(615)328.5588 - fax
(615)328.6637 - alternate fax

Medical Record #: _____

SS#: _____

<p style="text-align: center;">Release of Information <u>FROM</u> Trousdale Medical</p> <p>I authorize Trousdale Medical Center to release copies of my records as listed below. The information should be sent to:</p> <p>_____</p> <p>Name of Physician, Institution, Self (who the records are going to)</p> <p>_____</p> <p>Address</p> <p>_____</p> <p>City/St/Zip _____ Phone _____</p>	<p style="text-align: center;">Release of Information <u>TO</u> Trousdale Medical</p> <p>I authorize the release of information from:</p> <p>_____</p> <p>Name of Physician, Institution (where records are coming from)</p> <p>_____</p> <p>Phone _____ Fax _____</p> <p>Please send the requested records to:</p> <p>Dr. _____</p> <p>Phone: _____ Fax: _____</p> <p>Floor/Nurses Station Phone: _____</p> <p>Floor/ Nurses Station Fax: _____</p>
<p>DATES OF TREATMENT</p> <p>Dates: _____</p> <p>The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.</p>	
<p>*Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Trousdale Medical Center.</p>	
<p style="text-align: center;">Information to be Released</p> <p><input type="checkbox"/> Discharge Summary <input type="checkbox"/> EKG</p> <p><input type="checkbox"/> History & Physical <input type="checkbox"/> Lab</p> <p><input type="checkbox"/> Operative Report <input type="checkbox"/> Physician Orders</p> <p><input type="checkbox"/> X-ray <input type="checkbox"/> Sensitive (alcohol, drug, mental illness)</p> <p><input type="checkbox"/> Clinic Visits <input type="checkbox"/> HIV/AIDs, STD)</p> <p><input type="checkbox"/> ER Records</p>	<p style="text-align: center;">Purpose of Release</p> <p><input type="checkbox"/> Attorney <input type="checkbox"/> Disability</p> <p><input type="checkbox"/> Social Security <input type="checkbox"/> Insurance</p> <p><input type="checkbox"/> Continuation of Care <input type="checkbox"/> Deposition</p> <p><input type="checkbox"/> Workmen's Compensation <input type="checkbox"/> Billing</p> <p><input type="checkbox"/> Other (Please Specify Below)</p> <p>_____</p>

Expiration date for expressed authorization is _____. If the patient does not express a desire for a specific date or condition to revoke their authorization, this authorization will expire ninety (90) days from the date signed by the patient or legal representative.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist, as detailed by federal law, such as:

- TMC has taken action in reliance thereon, or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the Privacy Officer of Trousdale Medical Center. This revocation document must contain the signature of the patient or patient's legal representative. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Signature of Patient or Appropriate Legal Representative

Date

If applicable, relationship to patient

Photo ID was provided ____yes ____no If no, the form of patient identification must be so stated and a copy provided with the authorization
In order to be valid, the signature on the authorization must be after the date of service that is being requested for release.

Witness

Date

