



AUTHORIZATION TO RELEASE HEALTH INFORMATION

LeConte Women's Healthcare Associates

740 Middle Creek Road, Suite 200, Sevierville, TN 37862

PHONE: 865-908-9888 FAX: 865-331-1015

If any section is **INCOMPLETE**, this form may be **invalid**. You may be **charged for copies** in accordance with state law.

Patient Name: _____ Social Security Number: _____
Address: _____ Date of Birth: ____/____/____
City/State: _____ ZIP: _____ Phone: _____ EDD*: _____

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Is authorized to: (Mark only one option below)

_____ Complete Provider, Clinic, or Hospital Name

RELEASE Information **TO:**

_____ Street Address

or

OBTAIN Information **FROM:**

_____ Building or Suite Number

_____ City _____ State _____ ZIP

_____ Telephone _____ FAX

Purpose of Release:

- At the request of the Patient
- Continue Care for both providers
- Treatment
- Transfer of Care
- Legal Purposes
- Other: _____

Information to be Disclosed includes dates of service from _____ to _____ (records for particular dates of service may include historical information about the patient from prior visits to the facility.)

- Entire Medical Record
- Current Insurance and Policy Holder Information
- OP reports on or around: _____
- Other: _____
- Last PAP and OB/GYN Notes on or around: _____
- Lab and Ultrasound Reports on or around: _____

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, psychiatric or psychological treatment, and treatment for drug and/or alcohol use.

Expiration: I understand that unless I revoke the authorization earlier, this authorization will automatically expire on the later of the following: (1) One year after the date this authorization is signed or (2) On the occurrence of the following event: _____

I understand I may revoke this authorization at any time by sending a written notice to the provider above. Revocation will not affect any uses or disclosures provider(s) may have made before receiving revocation. I understand information used or disclosed in accordance with this authorization may no longer be protected by Federal law, and could be re-disclosed by the receiving party. I understand I may refuse to sign this authorization and that provider(s) will not condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization.

Signature: _____ Date: _____

Printed Name: _____

If signed by the patient's legal representative, please complete the following and attach appropriate documentation.

Relationship: Parent Guardian Conservator Other: _____

* Optional: Estimated Due Date for pregnancy

ONE COPY TO BE RETAINED BY THE PATIENT

Verification by Staff on Page 2 must be completed for *Authorization to Release Health Information* to be valid.

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THIS PAGE IS FOR STAFF USE ONLY:

1. Advise patient to fill out this form completely. We are not allowed to ADD or DELETE information to the *Authorization to Release Health Information* later.
2. NOTE: Hospital, Surgery, and Delivery Notes must be requested from the facility where service was performed. **Do not** request these records from the physician/provider that performed the services.
3. Expiration events may be final resolution of specific events; e.g., end of litigation, postpartum visit, etc.
4. Provide one form per request (i.e., obtain separate *Authorization to Release Health Information* forms for each hospital, provider, or clinic from which records are requested).
5. Review the form(s) for completeness before the patient leaves the office.
6. Staff member receiving the form should complete appropriate sections of page 2, sign, and list title; i.e., *Jane Doe, MD* or *John Law, Patient Acct Rep.*

For Staff Use Only:

Date Received: _____

Complete the applicable section below based on who signed the *Authorization to Release Health Information* form.

Patient Signed Form

Mark below how patient identity was verified. One photo ID is required if the patient signed the form. Identification marked below must be scanned into the patient's EMR chart for the *Authorization to Release Health Information* to be valid. Check to see if ID has already been scanned.

- | | |
|--|---|
| <input type="checkbox"/> Photo ID scanned in EMR | <input type="checkbox"/> Passport scanned in EMR |
| <input type="checkbox"/> EMR Photo | <input type="checkbox"/> Employer Photo ID scanned in EMR |
| <input type="checkbox"/> Driver's License scanned in EMR | <input type="checkbox"/> Signature Verification (must be verified by two staff members) |
| <input type="checkbox"/> Other Photo ID scanned in EMR; specify: _____ | |

Legal Representative Signed Form

Mark below how legal representative's identity was verified. Two forms of identification are required, and one must be a photo ID. Identification must be scanned into the patient's EMR chart for *Authorization to Release Health Information* to be valid. Check to see if ID has already been scanned.

- | | |
|---|--|
| <input type="checkbox"/> Legal Representative Driver's License | <input type="checkbox"/> Legal Representative Social Security Card |
| <input type="checkbox"/> Legal Representative Passport | <input type="checkbox"/> Legal Representative Birth Certificate |
| <input type="checkbox"/> Legal Representative Employer Photo ID | <input type="checkbox"/> Other ID, please describe: _____ |

Mark below how the legal representative's authority to sign the form on behalf of the patient was verified. The document marked below must be scanned into the patient's EMR chart for the *Authorization to Release Health Information* to be valid. Check to see if legal documents have already been scanned.

- | | |
|--|---|
| <input type="checkbox"/> Patient Birth Certificate | <input type="checkbox"/> Marriage Certificate |
| <input type="checkbox"/> Guardianship Papers | <input type="checkbox"/> Other Legal Document, please describe: _____ |
| <input type="checkbox"/> Attorney-In-Fact Appointment Papers | |

Complete the next two sections on all forms.

Copy of *Authorization to Release Health Information* provided to person who signed form. Yes No Signer refused copy of form

Signature: _____

Title: _____

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