Patient Request for Medical Records

PROVIDER AUTHORIZED TO RELEASE HEALTH INFORMATION (check all that apply):

☐Claiborne Medical Center ☐Cumberland Medical Center ☐Ft. Loudoun Medical Center ☐Ft Sanders Regional Medical Center
☐LeConte Medical Center ☐Methodist Medical Center ☐Morristown Hamblen Health System ☐Parkwest Medical Center
☐Peninsula Behavioral Health ☐Roane Medical Center ☐Thompson Cancer Survival Center ☐Covenant Home Care
☐PENINSULA OUTPATIENT CLINICS:☐ Blount ☐ Knoxville ☐ Loudoun ☐ Sevier ☐ IOP ☐ WIT

Other:____

Patient's Name: ______________________ Date of Birth: __________ Med. Rec. #: __________
SS# (last 4) or DL#: ______________________ Phone # :______________________________

I, or my legally authorized patient representative, am requesting that any Covenant Health Hospital/Facility listed above ☐ **release** the following medical records to **or** ☐ **obtain from:**
☐ Myself or ☐ ____

Method of Delivery / Pick-up / Special Instructions:
☐ Pick-up ☐ Fax: __________________ ☐ Mail to the following address:

Address: ____

Special Instructions/E-mail: ____
☐ E-Mail (unencrypted - If requested, the patient agrees to accept the risk that the records / personal health information could be read or otherwise accessed by a third party while being transmitted.)

The medical record information to be disclosed includes only those items checked below, with respect to services provided on or around ______________________. I understand this information may include, but is not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to Acquired Immune Deficiency Syndrome/HIV.

- ☐ Entire medical record, other than psychotherapy notes (separate authorization required for psychotherapy notes*);
- ☐ OR - the following parts of the medical record:

☐ Discharge Summary	☐ Progress Notes	**PENINSULA SPECIFIC:**
☐ History and Physical Exam	☐ EKG/s ☐ ECHO ☐CDs	☐ Assessment(s)
☐ Consultation Report/s	☐ Photographs, videotapes, or other image	☐ Treatment(s)/Therapies
☐ Operative Report	☐ HIV Test Results and Treatment	☐ Substance Use Disorder
☐ Pathology Report	☐ Mental or Behavioral Health	**OTHER:**
☐ Emergency Room Record	☐ Physical/Occupational/Speech Therapy	
☐ Lab Results	☐ Cardiac Rehabilitation	
☐ Radiology Report/s ☐ CDs	☐ Implant Records	

Certification: I certify I am *(check whichever applies)*:

- ☐ The Patient and the identification that I have provided are true and correct.
- ☐ The Patient's authorized representative, and that the identification and proof of authority I provided are true and correct. My relationship to the patient is that of: ____________________.

☐ Verbal/Phone Consent obtained from: ____

Signature: ____________________________ Printed Name: ____________________________

Date: ________ Time: ________ Authority Document: ____________________________

For Provider Use Only: Date received: ____________________ Date processed: ____________________
How was identity verified? ______________________________ Copy made? ☐ Yes ☐ No
How was authority verified? ______________________________ Copy made? ☐ Yes ☐ No
By: ______________________ Title: ____________________ Released Incomplete: __________

Account #'s Released: ____