

**AUTHORIZATION TO RELEASE HEALTH INFORMATION****Fort Sanders Perinatal Center and Fort Sanders Women's Specialists**

501 19th Street, Trustees Tower, Suite 401, Knoxville, TN 37916

PHONE: 865-331-2020 or 865-331-1122 FAX: 865-331-1976

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

Building or Suite Number

 OBTAİN Information **FROM:**

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 Last PAP and OB/GYN Notes on or around: _____ OP reports on or around: _____ Lab and Ultrasound Reports on or around: _____ Other: _____ I

understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV and other sexually transmitted diseases, 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: _____

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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: _____

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.