PATIENT REQUEST FOR MEDICAL RECORDS

Covenant HEALTH
LeConte Women's Healthcare Associates

Last Name	First Name	Middle Name	Preferred Phone

Date of Birth	Social Security Number	EDD (Estimated Delivery Date), if pregnant

740 Middle Creek Rd Ste 200
Sevierville, TN 37862-5056

LeConte Women's Healthcare
is authorized to

Ph: 865-908-9888
FAX: 865-331-1015
Email: pnchim@covhlth.com

Mark only one choice:

☐ Obtain medical records from **OR** ☐ Release medical records to

☐ Patient ☐ Provider/Clinic/Hospital: _____

Phone Number: _____ FAX Number: _____

Method of Delivery / Pickup / Special Instructions

☐ Pick up ☐ Fax Records to: _____

☐ Mail to the following address: _____

☐ Email (If requested, the patient/patient authorized representative consents to receiving protected health information via email and understands that records and messages sent through this type of communication may not be secure.)

Special Instructions/Email Address: _____

Information to be Disclosed

The medical record information to be disclosed includes only those items checked below, with respect to services provided on or around (insert date): _____.
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 or other sexually transmitted diseases.

Please provide the following parts of the medical record:

☐ Demographics, Current Insurance and Policyholder Information ☐ Last PAP and OB/GYN Notes _____

☐ Lab reports _____ ☐ Operative reports _____

☐ Ultrasound reports _____ ☐ Other: _____

OR ☐ Entire medical record, other than psychotherapy notes, which require a separate authorization

Certification

☐ I certify I am the Patient, and the identification that I have provided is true and correct.

☐ I certify I am the Patient's Authorized representative and that the identification and proof of authority I provided are true and correct.

Relationship to Patient: _____ Legal Rep. Authority Document: _____

Signature: _____ Date: _____ Time: _____ Printed Name: _____

For Provider Use Only Date Received _____ Date Processed _____

IDENTITY: How was it verified? _____ Copy Made? ☐ Yes ☐ No

AUTHORITY: How was it verified? _____ Copy Made? ☐ Yes ☐ No

By: _____ Title: _____ Release Incomplete: _____

☐ Verbal/Phone Consent obtained from: Account#'s Released: _____

Provide copy of form to patient/legal representative

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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.

[ ] Photo ID scanned in EMR
[ ] Passport scanned in EMR
[ ] EMR Photo
[ ] Employer Photo ID scanned in EMR
[ ] Driver's License scanned in EMR
[ ] Signature Verification (must be verified by two staff members)
[ ] 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.

[ ] Legal Representative Driver's License
[ ] Legal Representative Social Security Card
[ ] Legal Representative Passport
[ ] Legal Representative Birth Certificate
[ ] Legal Representative Employer Photo ID
[ ] 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.

[ ] Patient Birth Certificate
[ ] Marriage Certificate
[ ] Guardianship Papers
[ ] Other Legal Document, please describe: _____
[ ] 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.