To Whom It May Concern:

Please fill out the attached forms completely. Be specific on the requested information such as: The hospital attended, dates of service, and medical records needed. **A state issued photo I.D. must be included.** If you are requesting records on a relative, **legal proof of relationship must be enclosed.** Please be aware that per TN State law 68-11-304(a) (2), there may be a fee for your obtaining a copy of medical records.

We will accept your request back, via U.S. mail, to the fax number or to the address below. If you prefer, you may present to the Hospital you were treated at. **The below address is for mail return only.**

Our normal processing time is ten days. If forms are not complete and we are missing any of the above information, it may cause a delay in processing.

Please call the number below, we will be happy to assist you with any questions you may have.

Thank You.

Covenant Health HIM Department
1400 Centerpoint Blvd.
Ste 172
Knoxville, Tn. 37932
865-374-5269(P) 865-374-2038(F)

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)/Therápies
☐ 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: ____________________________

Effective 12/9/19

REQUEST FOR PROTECTED HEALTH INFORMATION FROM PATIENT (APPLICABLE COSTS PER FACILITY)

The release of patient medical information is governed by Federal and Tennessee state statutes. We will send a copy of records to the patient's physician without cost. Please provide the full name and address of the physician on the authorization.

For copies of records provided at patient request, the below describes fees that will be charged based on federal law.

Normal and customary charges assessed for providing copies of medical records on CD, in electronic format, or paper format based on the following:

> **For records provided in electronic or paper format (including labor, materials, and shipping: $6.50**
>
> Please note that unusually large or resource-involved requests may involve additional charges. We will notify you before processing a request that involves additional charges.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records.

PLEASE PRINT:

NAME:________________________________ PHONE #:(   )__________

ADDRESS:____
Street City State Zip

SIGNATURE:____________________________ DATE:______________