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 ☐ MAT

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 / Special Instructions:
Fax☐_____ ☐ Mail to the following address:

Address: _____

Special Instructions/E-mail: _____
☐ E-Mail (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.)

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: _____

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 cost:

For records provided in electronic or paper format(including labor, materials, and shipping) $6.50

For an additional CD (including imaging) $5.00 per CD may apply,

We accept checks, credit/debit cards and money orders only.
We do not accept cash payments.

Please choose ONE form of delivery: __Email ___CD ___Paper

Please note that unusually large or resource-involved requests may involve additional charges.
We will notify you before processing a request that involves any 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:***_____

Release of Information Department
1400 Centerpoint Blvd, Suite 172
Knoxville, TN 37932
Phone: (865) 374-5269 Fax: (865) 374-2038

To Whom it May Concern:

In order to receive a copy of the deceased patient's records, there are specific legal documents required to show proof of legal authority to sign. The specific order is below:

1. *Executor of Estate (goes to probate and the judge signs stating who is executor)*

   If there is not an executor of estate:

2. *The spouse will need to sign a next of kin form* ***(attached)*** *and have it notarized, and provide marriage certificate.*

   if there is not a living spouse:

3. *ALL living children over the age of 18 will need to sign next of kin form, provide their birth certificates (long form with parents listed), and sign authorization.*

   No living children/No spouse:

4. *Living parents will have to sign next of kin form, provide full birth certificate.*

In addition to the documents listed above, the following are required: copy of death certificate, state issued identification of requestor, along with signed authorization attached.

All documents must be presented and reviewed before request will be processed. Any missing documents may cause a delay in processing.

Thank You,

Release of Information

Covenant HEALTH

ACCOUNT NUMBER/S: _____

□CLMC □CMC □CMG □FLMC □FSRMC □LMC □MHHS □MMC □PMC □PMMH □RMC □TCSC □Home Care

CERTIFICATION BY NEXT OF KIN

TO: _____(Provider)

DECEASED PATIENT'S NAME: _____

PERSON MAKING REQUEST: _____

I HEREBY CERTIFY THAT THE FOLLOWING STATEMENTS ARE TRUE AND ACCURATE:

1. Neither the Decedent nor the Decedent's estate has a legal representative (e.g., an executor, administrator, or other representative appointed by a court in connection with administration of the Decedent's estate).

2. The Requesting Party is the Decedent's surviving spouse, or if there is no surviving spouse, the Decedent's surviving next-of-kin.

REQUESTING PARTY

_____ _____

SIGNATURE **PRINTED NAME**

DATE_____/_____/_____ **TIME** _____

NOTARY PUBLIC

State of _____) County of _____)

On this ___ day of _____, 20____ before me personally appeared_____, to me known or proved to be the person described herein and who executed the foregoing instrument, and acknowledged that such person executed the same as such person's free act and deed.

Sworn and subscribed before me this _____ day of _____, 20____.

_____

Notary Public
My Commission Expires: _____

NOTE: *[MUST BE PRESENTED TOGETHER WITH THE PATIENT'S DEATH CERTIFICATE, EVIDENCE OF THE FAMILIAL RELATIONSHIP BETWEEN THE DECEDENT AND THE REQUESTING PARTY, A COPY OF THE APPLICATION FOR THE BENEFITS AT ISSUE, AND A COMPLETED HIPAA AUTHORIZATION AUTHORIZING RELEASE OF THE DECEDENT'S PROTECTED HEALTH INFORMATION THAT IS SIGNED BY THE REQUESTING PARTY AS DECEDENT'S PERSONAL REPRESENTATIVE. THE REQUESTING PARTY'S IDENTITY MUST BE VERIFIED IN ACCORDANCE WITH HIPAA POLICY LDR.IC.HIPAA.002, PERSONAL REPRESENTATIVES AND AUTHORITY TO EXERCISE PRIVACY RIGHTS.]*

Covenant HEALTH

ACCOUNT NUMBER/S: _____

□CLMC □CMC □CMG □FLMC □FSRMC □LMC □MHHS □MMC □PMC □PMMH □RMC □TCSC □Home Care

ALL OTHER NEXT OF KIN

SIGNATURE	PRINTED NAME	DATE
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