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. For record requests on a relative, legal proof of relationship is required. Please be aware that per TN State law 68-l l-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, or by fax to the number shown below. **The below address is for mail return only. We do not accept drop offs/walk-ins**

We strive to keep processing time down to ten business days per HIPAA. If forms are not filled out completely and missing any of the above information, it may cause a delay in our processing.

For faster service, you may call our office to be set-up on our patient portal or to receive an electronic record request via email. Delivery of records will returned via email, mail, or fax. Our patient portal allows you to view, download, and print your medical records at your convenience.

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

Covenant Health HIM Department **(Mail Only)**

1400 Centerpoint Blvd.

Suite 172

Knoxville, TN 37932

865-374-5269(P) 865-374-2033(F)

Thank You for choosing Covenant Health

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 (not including billing records, certain images, and Good Faith Estimates), 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:***_____