**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

## Cumberland Women's Healthcare

49 Cleveland Street, Suite 340, Crossville, TN 38555-2854
PHONE: 931-459-7911 FAX: 865-374-1039

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)

[ ] **RELEASE** Information **TO:**

or

[ ] **OBTAIN** Information **FROM**:

_____
Complete Provider, Clinic, or Hospital Name

_____
Street Address

_____
Building or Suite Number

_____ _____ _____
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
[ ] OP reports on or around:_____
[ ] Last PAP and OB/GYN Notes 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:_____

***** Optional: Estimated Due Date for pregnancy



Rev 1/1/2026

**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.

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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.

[ ] 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:_____



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