



ACCOUNT NUMBER: _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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 Loudon Sevier IOP WIT MAT

Other: _____

Patient Name: _____

Date of Birth: ___/___/___ **Date of Death, if applicable:** ___/___/___ **Social Security Number:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

The information is to be disclosed to the following persons or organizations (Self or Authorized Receiving Party):

Name/Title: _____ **Phone:** _____ **Fax:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Purpose: At the request of patient Legal Purposes Treatment 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
OR

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes	PENINSULA SPECIFIC:
<input type="checkbox"/> History and Physical Exam	<input type="checkbox"/> EKG/s <input type="checkbox"/> ECHO	
<input type="checkbox"/> Consultation Report/s	<input type="checkbox"/> Photographs, videotapes, or other image	<input type="checkbox"/> Treatment(s)/Therapies
<input type="checkbox"/> Operative Report	<input type="checkbox"/> HIV Test Results and Treatment	<input type="checkbox"/> Substance Use Disorder
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> Mental or Behavioral Health	OTHER:
<input type="checkbox"/> Emergency Room Record	<input type="checkbox"/> Physical/Occupational/Speech Therapy	
<input type="checkbox"/> Lab Results	<input type="checkbox"/> Cardiac Rehabilitation	
<input type="checkbox"/> Radiology Report/s <input type="checkbox"/> CDs	<input type="checkbox"/> Implant Records	

I understand that this information may include, but is not limited to, information related to Acquired Immune Deficiency/HIV, 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 each provider marked 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. I understand that there may be a reasonable copying fee, as permitted by applicable law.

SIGNATURE _____ **DATE** ___/___/___ **TIME** _____

If signed by patient's legal representative please complete the following and attach appropriate documentation

Printed Name: _____ **Relationship:** _____

FOR PROVIDER USE ONLY

How was identity verified? _____ Copy made? Yes No

How was authority verified? _____ Copy made? Yes No

By: _____ Title: _____ Date: _____

Picked up Mailed Faxed Date: ___/___/___ Released by: _____