

Authorization to Release Protected Health Information

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|---|-------------------------------|-------------------|
| <input type="checkbox"/> Maury Regional Medical Center* | Phone: 931-380-4089 | Fax: 931-380-4092 |
| <input type="checkbox"/> Lewis Health Center* | Phone: 931-796-6236 | Fax: 931-796-6243 |
| <input type="checkbox"/> Wayne Medical Center* | Phone: 931-722-2035 | Fax: 931-722-7170 |
| <input type="checkbox"/> Marshall Medical Center* | Phone: 931-359-6241, ext 3326 | Fax: 931-270-3616 |

Patients Name: _____ Birth Date: _____ Last 4 digits of S.S. # _____

Address: _____ Phone # _____

I authorize the facility specified above to:

Disclose my health information to: _____
(Name and Address) – Specify: Attorney, Insurance, Self, etc)

Obtain/request copies of my health information from: _____
(Name and Address) – Specify: Hospital, Physician, etc.

I authorize use and/or release of information covering treatment from: _____ to: _____
(enter specific dates)

PURPOSE: Further Care Legal Insurance Payment or Billing Patient Request

Information to be used and/or disclosed:

- Abstract (History & Physical, Discharge Summary, Consults, Operative Report, and Pathology, if applicable)
- Lab Reports Radiology Reports Emergency Department Records Billing
- Other _____

- I understand that the release of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).
- This authorization will remain in effect for **one (1) year** after the date recorded below.
- This authorization can be revoked at any time with a written request to the specified facility's HIM Department (Medical Records).
- Revoking the authorization stops further disclosures but cannot undo any disclosures that may have already occurred.
- I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by Federal privacy regulations.
- I understand that I do not have to sign this authorization in order to receive treatment, payment or eligibility of benefits.

The facility is authorized to furnish this information even though the confidentiality of the information may be protected by Federal and State law and regulations. The facility is hereby released and discharged of any liability, and I will hold the facility harmless for complying with this authorization.

Signature of Patient or Authorized Individual

Date

Relationship and/or authority to act for the patient

Phone #

If the above signature is not that of the patient, please explain why. Documentary evidence of guardianship may be required to accompany this form.

Photo ID was provided: Yes No If no, specify form of patient identification: _____

