ACCOUNT NUMBER:_____

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
❑ Other: _____
□ PENINSULA OUTPATIENT CLINICS: □ Blount □ Knoxville □ Loudoun □ Sevier □ IOP □ WIT

AUTHORIZATION TO RELEASE HEALTH INFORMATION

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 ❑Other: _____

INFORMATION TO BE DISCLOSED includes dates of service from _____ to _____

❑ **Entire medical record**

OR

❑ Discharge Summary	❑ Progress Notes	**PENINSULA SPECIFIC:**
❑ History and Physical Exam	❑ EKG/s	❑ 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	❑ 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: _____