# Sweetwater Hospital Association (SHA)

Medical Record # _____

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**PATIENT IDENTIFICATION**: Name:_____

Patient Phone # _____ DOB: _____S.S.#_____

**PROVIDER** (Who is releasing information):

☐ Sweetwater Hospital Association records

☐ Dr. _____ Professional Clinic records

☐ Other: _____

## HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

Information is to be ☐ Mailed ☐ Faxed ☐ Picked-up ☐ Electronic (CD, email, other) Please specify:

**FAX NUMBER** (If information is able to be faxed): _____

**E-MAIL ADDRESS:**_____

(***Note**: If I elect to have my records emailed to an e-mail address of my choice I am aware that this is an **unsecure** method of transmitting my personal health information (45 CFR 164.524(c)(2)(i) and (ii).)*

## RELEASE RECORDS TO (Person or Place records should be sent):

☐ Sweetwater Hospital Association
ATTN: _____
304 Wright Street, Sweetwater, TN 37874

☐ Name: _____

Note: If information is to be picked up by someone other than the person authorized to sign, this person must be named above, and positive identification is required at the time of pick-up.

Address: _____

City: _____

State/Zip:_____

Phone #: _____

## DATES OF SERVICE (Dates/Account #):

## INFORMATION TO BE RELEASED:

| **Hospital** | **Professional Clinic Records** | **Other Records** |
|---|---|---|
| □ Hospital abstract (DS, H&P, Op Note, Path, lab, x-rays, EKG, sleep study, any other diagnostic study, face sheet)<br>□ Hospital chart complete (a charge will be incurred)<br>□ Emergency Room Record<br>□ Radiology reports<br>□ Imaging<br>□ Lab<br>□ EKG<br>□ Other: _____ | □ Office Notes<br>□ Nurses Notes<br>□ Diagnostic studies (EKG, sleep studies).<br>□ Lab<br>□ Radiology Reports | □ Home Health Records<br>□ Physical Therapy Records<br>□ Billing/Records<br>□ Industrial Medicine<br>□ Other: _____ |

## PURPOSE OF RELEASE:

- □ At the request of the patient
- □ Social Security
- □ Continuation of Care
- □ Insurance
- □ Billing
- □ Marketing (If this request is at the request of a "covered entity" for marketing purposes, the provider must state if they □ will or □ will not receive direct or indirect compensation for the use or disclosure of this information).

- □ Attorney
- □ Workmen's Compensation
- □ Disability
- □ Deposition
- □ Other:

## PREFERENCE FOR RECEIVING REQUESTED RECORDS

- □ Disc
- □ Hard copy

*All PACS images will **ONLY** be released on disc.*

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status.**

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released. **Limitations, if any to be released**:

## TIME LIMIT:

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition

_____.

## SIGNATURES:

Signature of Patient/Legal Representative: _____ Date: _____

Witness Signature:_____ Date: _____

(**NOTE:** If the patient is represented by another person, please include a description of your legal authority to act for the individual and (if applicable) attach a copy of the proof of legal representation. For example, a Durable Power of Attorney for Health Care is sufficient if the patient is unable to make their own health care decisions. A Durable Power of Attorney containing TCA 34-6-109 authorizes the representative to obtain medical records. A Durable Power of Attorney containing TCA 34-6-204 (2017) allows the designated individual in the Durable Power of Attorney make health care decisions for the principal, before or after the death of the principal.)

**Relationship to Patient**: □ Self □ Other: _____

Photo ID was provided _____Yes _____No. If no, the form of identification must be so stated and a copy provided with the authorization. In order to be valid the signature on the authorization must be after the date of service that is being requested for release. If other form of identification used (specify):_____

If the SHA staff need more information to process this request or need to contact you regarding fees, how may we contact you? Daytime Phone #:_____ Other means: _____

**How to REVOKE your Authorization for Release of Medical Information**
You have the right to revoke your Authorization for Release of Medical Information. To do so you must send us a written letter revoking your authorization. The letter should be mailed to the following address:

Sweetwater Hospital Association
ATTN: Health Information Management Department
304 Wright Street
Sweetwater, Tennessee 37874

If you have any questions please call our department at 865-213-8400.

**Exceptions: This authorization may be revoked except to the extent that:**
- Sweetwater Hospital has taken action in reliance thereon: or
- If the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.

**PLEASE NOTE:**
When your medical information is released pursuant to a valid authorization you should be aware of the following:
*That the information released may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule.*
**TREATMENT MAY NOT** be withheld, or conditioned on obtaining this authorization

## **********For SHA Use Only**********

**Method of release** □ Hard copy □ Disc

Release Completed by: _____ Date: _____

Release picked-up/mailed/faxed date: _____

NOTE: _____

RELATIONSHIP TO DECEASED WITNESS/DATE

**PATIENT IDENTIFICATION**: Name:_____

Patient Phone # _____ DOB: _____S.S.#_____

**VERIFICATION OF PROPER RELEASE FOR DECEASED PATIENT**

- A patient's authorization does not survive his or her death
- Power of Attorney is revoked by the death of the principal (patient)
- Has an executor/executrix of the patient's estate been appointed? _____Yes _____No
    - If yes, the executor/executrix of the patient's estate should sign the authorization for release of information.
- **To be completed by EXECUTOR/EXECUTRIX**
- Name of executor/executrix (Copies from the court and proof of ID must be provided and attached):

_____ _____

SIGNATURE OF EXECUTOR/EXECUTRIX Date

_____ _____

WITNESS Date

**To be completed by Next of Kin and only if there is no Executor/Executrix. The order listed below is priority for next of kin.**

- Is there a living competent legal spouse?
- _____ Yes _____ No
- If yes, list name:_____

- If no spouse is there a competent adult son or daughter?
- _____ Yes _____ No
- If yes, list name:_____

- If no adult son or daughter is there a competent parent still living?
- _____ Yes _____ No
- If yes, list name:_____

- In the absence of all of the above is there a competent adult brother or sister living?
- _____ Yes _____ No
- If yes, list name:_____

- **PROBATE MATTERS:** Public Chapter 886 – Provides that the above person(s) may execute a medical records release authorization that may be required by an insurance company that issued the life insurance policy or annuity contract in connection with a claim for death benefits payable under a life insurance policy or an annuity contract:
    - _____ The personal representative of the decedent's estate, if any;
    - _____ A beneficiary of the death benefits named in the policy or contract; or
    - _____ A person who has filed a small estate affidavit in the policy or contract; or
    - _____ A person who has filed a small estate affidavit in connection with the decedent's estate.

**Proof of relationship must be provided and attached to this form.**

SIGNATURE OF NEXT OF KIN DATE

## What we will provide at no cost to you:

- Records to your physician for continuing care. Pertinent information (abstract) for your own personal use includes transcribed reports (discharge summary, history and physical, operative reports, consultations, pathology reports, ER records, radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent please specify on the authorization what records are to be sent. **Each additional request for the same information will necessitate a charge.**

## Charges

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party.

Electronic Records (Hospital or Physician Professional Records) - records maintained in the electronic medical record)- $6.50

SHA reserves the right to exercise the reasonable time of 10 days upon receiving the written request under T.C.A.§ 63-2-101 to provide the requestor with the requested health information.