

Patient's Name _____

Patient's Address _____

City, State, Zip: _____ Date of Birth: _____

Telephone No. _____ Medical Record #: _____ #SS _____

Erlanger Health System
Health Information Management
975 East Third Street
Chattanooga, TN 37403
(423)778-4185 • (423) 778-4179

Release of Information from Erlanger

I authorize Erlanger Health System to release copies of my record as listed below. The information should be sent to:

Name of Physician, Institution, Self, etc.

Address

City, State, Zip

Telephone Number Fax Number

* Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Erlanger Health System.

Release of Information to Erlanger

I authorize the release of information from:

Name of Physician, Institution, etc.

Address

City, State, Zip

Please send information requested below to:

Dr. _____

Dept/Clinic _____

Telephone Number _____ Fax Number _____

DATES OF TREATMENT (Which dates of treatment do you need records for?)

Dates: _____

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

Information to be Released

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> EKG | <input type="checkbox"/> Clinic Visits |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Lab | <input type="checkbox"/> ER Records |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Physicians Orders | |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Other | |

Reason for Disclosure

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Attorney | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Continuation of Care | <input type="checkbox"/> Deposition |
| <input type="checkbox"/> Workmen's Compensation | <input type="checkbox"/> Billing |
| <input type="checkbox"/> Other (Please Specify Below) | |

Expiration date for expressed authorization is _____. If the patient does not express a desire for a specific date or condition to revoke their authorization, this authorization, will expire ninety days from the date signed by the patient or legal authorized agent.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representation is allowable only in the event that release of information has not already occurred. Specific expectations to revoke an authorization exist, as detailed by federal law, such as:

- EHS has taken action in reliance thereon, or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to ;the Privacy Officer of Erlanger Health System. This revocation document must contain the signature of the patient or patient's legal representative, and that signature must be formally certified by a Notary Public.

I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

Signature of Patient or Appropriate Legal Representative _____ Date _____

(If a personal representative of the individual signs the authorization, a description of such representative's authority to act on behalf of the individual must be provided)

Relationship If Not Patient

Photo ID was provided ____ yes ____ no. If no, the form of patient 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.

Witness _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION



Page 1 of 2

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Patient Information