AUTHORIZATION TO RELEASE HEALTH INFORMATION

Fort Sanders Perinatal Center and Fort Sanders Women's Specialists

501 19th Street, Trustee Tower, Suite 401, Knoxville, TN 37916
PHONE: 865-331-2020 or 865-331-1122 FAX: 865-331-1976

If any section is **INCOMPLETE**, this form may be **invalid**. You may be **charged for copies** in accordance with state law.

Patient Name:_____ Social Security Number: _____
Address:_____ Date of Birth:_____/_____/_____
City/State:_____ Zip:_____ Phone:_____ EDD*:_____

[ ] 1. RELEASE Information **TO:**

Provider & Clinic Name OR Individual Contact:

_____
Attention:_____
Address:_____
City/State:_____
PH:_____ FAX: _____

FROM: Fort Sanders Perinatal Center and
Fort Sanders Women's Specialists
PH: 865-331-2020/1122 FAX: 865-331-1976
501 19th Street, Suite 401, Knoxville, TN 37916

OR

[ ] 2. OBTAIN Information **FROM:**

Full Hospital Name OR Provider & Clinic Name:

_____
_____
Address:_____
City/State:_____
PH:_____ FAX: _____

TO: Fort Sanders Perinatal Center and
Fort Sanders Women's Specialists
PH: 865-331-2020/1122 FAX: 865-331-1976
501 19th Street, Suite 401, Knoxville, TN 37916

Purpose of Release:

[ ] Continue Care for both providers
[ ] At the request of the Patient
[ ] Transfer of Care
[ ] Other: _____
[ ] Legal Purposes

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
[ ] OP reports on or around:_____
[ ] Other: _____
[ ] Last PAP and OB/GYN Notes on or around:_____
[ ] Lab and Ultrasound Reports on or around:_____

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 following:

[ ] One year after the date this authorization is signed or
[ ] On the occurrence of the following event: _____.

I understand I may revoke this authorization at any time by sending a written notice to the provider 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.

Signature:_____ Date: _____
Printed Name: _____

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

Relationship: [ ] Parent [ ] Guardian [ ] Conservator [ ] Other: _____

*OPTIONAL: Expected Delivery Date for pregnancy

Rev 6/23/2020

ONE COPY TO BE RETAINED BY THE PATIENT

Verification by Staff on Page 2 must be completed for Authorization to Release Health Information to be valid.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Fort Sanders Perinatal Center and Fort Sanders Women's Specialists
501 19th Street, Trustee Tower, Suite 401, Knoxville, TN 37916
PHONE: 865-331-2020 or 865-331-1122 FAX: 865-331-1976

For Provider Use Only:

Date Received: _____ Charges:_____Paid on:_____/_____/_____

How was Identity Verified: 1)_____ 2)_____Copy scanned/attached: [ ] Yes [ ] No

How was Authority Verified:_____Copy scanned/attached: [ ] Yes [ ] No

Copy of Authorization to Release Health Information provided to patient. [ ] Yes [ ] No

Received and Verified by:_____Title:_____

STAFF:

1. Allow/Advise patient to fill out this form completely. We are not allowed to ADD or DELETE information to the Authorization to Release Health Information later.
   - NOTE: Hospital, Surgery, and Delivery Notes must be requested from the facility where service was performed. **Do not** request these records from the physician/provider that performed the services.
2. If Patient signs Authorization to Release Health Information, then:
   - Verify identity with a photo ID. Scan into EMR if not already on file.
   - May utilize the EMR PHOTO for existing patients that have provided photo ID at registration.
3. If Authorized Representative signs Authorization to Release Health Information, then:
   - Verify identity with **two** forms of identification, one of which must be a photo ID. Acceptable forms of identification are: driver's license, birth certificate, passport, social security card. Scan IDs into EMR.
   - Verify authority for any ***GUARDIAN, CONSERVATOR, or POWER OF ATTORNEY*** with a legal document. Scan legal document(s) into EMR. Acceptable documents include birth certificates, marriage certificates, passports, guardianship papers, attorney-in-fact appointment papers, or similar official certification.
   - If the representative does not have the proof of authority outlined above, consult with Practice Manager/Privacy Officer.
4. Expiration events may be final resolution of specific events; e.g., end of litigation, postpartum visit, etc.
5. Provide one form per request (i.e., obtain separate Authorization to Release Health Information forms for each hospital and each provider/clinic request for records).
6. Person receiving the form should complete shaded section of page 2, sign, and list title; i.e., *Jane Doe, MD* or *John Law, Patient Account Rep*.
7. **Provide a copy of each Authorization to Release Health Information to patient or representative, if applicable.**

Verification by Staff on Page 2 must be completed for Authorization to Release Health Information to be valid.