

Request Received: Date: _____ Time: _____ MR# _____

AUTHORIZATION ACCESS AND RELEASE OF CONFIDENTIAL HEALTH INFORMATION

This form is designed for CRMC employees and medical staff members/affiliates to access, view or copy/print own health information or that of family/significant others, or to give permission for others to access their records. This form must be turned in to the Medical Records Department prior to access. All yellow/shaded portions must be completed.

TO:
Medical Records
Cookeville Regional Medical Center ("CRMC")
1 Medical Center Boulevard
Cookeville, TN 38501
Phone: 931-783-2625; Fax: 931-783-2627

Patient's Full Name: _____
Date of Birth: _____/_____/_____
Social Security No: _____-_____-_____

Person/Organization Authorizing or Requesting Release of Information:

Patient Patient's Personal Representative***(See note on last page.)*

Specific Person(s)/Organization(s) or Class of Persons Authorized to Access, View or Receive the Information:

(Note: If designating family members, please give specific names and relationship so it is clear.)

Purpose of Access or Disclosure:

At the Request of the Individual *(This is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.)*

Other: _____

Please Describe the Information to be Accessed, Viewed or Released :

All Available Past and Future Medical and Billing Records in CRMC's Designated Record Set, as They are Needed or Requested. If the authorized individual is a current CRMC employee with computer access to protected health information, this gives them permission to access, view and/or print information.

Limited Access--If there are any limitations to what the authorized individuals should be given access to, state what is allowed to be accessed or released here. This includes limited access to only certain dates of service, only records created prior to the signature on this authorization (such as not future records), etc. :

This Authorization Will Expire On: ____/____/____ **or Upon:** _____
Date Specific Event

Note: Specific Event can be "until death." If you give authorization to a spouse and then later get divorced, you will have to revoke this authorization. It is not advisable to put an event as "until my death unless we get divorced," because it would not be feasible for us to verify that someone is NOT divorced, since papers could be filed anywhere.

I authorize Cookeville Regional Medical Center ("CRMC") to release my confidential health information as described above. I understand that I have a right to inspect or obtain a copy of my health information as permitted under state or federal law. I understand that the specific information to be disclosed **may** include testing or treatment for drug or alcohol abuse, mental health, Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), if applicable.

I understand that information disclosed has the potential for **re-disclosure by the recipient** and may no longer be protected by federal privacy regulations.

I understand that I have the right to **revoke** this authorization, **in writing**, at any time by sending such written notification to the **Privacy Officer** at CRMC. I understand that revoking this authorization stops any further disclosures, but cannot undo any disclosures that have already occurred as requested in the original authorization.

I may refuse to sign this authorization. CRMC may not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for this requested use or disclosure, unless it is required in order to participate in research-related treatment.

I understand that CRMC may charge a reasonable fee for the supplies, labor and postage involved in copying and mailing this information, unless otherwise limited by law. CRMC will either notify you or send an invoice if there is an associated fee.

X _____ **Current Date:** ____/____/____

PATIENT SIGNATURE (or Personal Representative**)

****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 Power of Attorney for managing finances only authorizes the representative to obtain billing/payment records.

If Patient is Unable to Sign, State Reason: _____

Relationship to Patient: Self Other: _____

If the CRMC staff need more information to process a future request or need to contact you, how may we contact you?

Daytime Phone #: _____ **Other Means:** _____

-----**For CRMC Use Only**-----

If information is requested from and given to non-CRMC employee or affiliate with computer access:

Identification: Driver's License # _____ State: _____
 Other, specify: _____

Release Completed by: _____ Date: _____