|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OF C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ONFIDENTIAL HEALTH INFO                                                                                                      | RMATION                                     |  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|--|--|
| ·O:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Patient's Full Name:                                                                                                         | Patient's Full Name:                        |  |  |
| Medical Records Cookeville Regional Medical Center ("CRMC") Medical Center Boulevard Cookeville, TN 38501 Phone: 931-783-2625; Fax: 931-783-2627                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Date of Birth.                                                                                                               | Date of Birth:                              |  |  |
| Person/Orga<br>Patient                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | anization Requesting R                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                              | representative **(See note on last page.)   |  |  |
| <b>)</b> Physician, Ho                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ospital or Other Health Care Pi                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | rovider                                                                                                                      | ☐ Health Plan or Insurance Company          |  |  |
| Patient's Atto                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | rney                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ☐ Other: Specify                                                                                                             | ☐ Other: Specify                            |  |  |
| specific Per                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | son(s)/Organization(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | or Class of Persons Authoriz                                                                                                 | ed to Receive the Information:              |  |  |
| i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | •                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | tification is required at the time of pick-up                                                                                | .)                                          |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | tification is required at the time of pick-up                                                                                | ss):                                        |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be mailed):  (If information is is Able to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e accessed by web-based acce                                                                                                 | ss):                                        |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be mailed):  (If information is is Able to                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | e accessed by web-based acce be Faxed:) ()  be Released (Mark all that ap                                                    | ss):                                        |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be established):  (If information is is Able to established):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | be Released (Mark all that ap                                                                                                | ss):                                        |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be cribe the Information to Discharge Summary                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | be Released (Mark all that ap                                                                                                | ss):  oply):  Imaging Films/Studies         |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be cribe the Information to  Discharge Summary History & Physical                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | be Released (Mark all that ap  Abstract of Key Reports  Laboratory Reports                                                   | ss):  oply):  Imaging Films/Studies         |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be cribe the Information to  Discharge Summary History & Physical Consultations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | be Released (Mark all that ap  Abstract of Key Reports  Laboratory Reports  X-Ray/Imaging Reports  Complete Acute Care Chart | ss):  oply):  Imaging Films/Studies         |  |  |
| Address (If i                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | named above, and positive identification is to be mailed):  ess (If information is to be cribe the Information to  Discharge Summary History & Physical Consultations Operative Reports                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | be Released (Mark all that ap  Abstract of Key Reports  Laboratory Reports  X-Ray/Imaging Reports  Complete Acute Care Chart | ss):  pply):  Imaging Films/Studies  Other: |  |  |
| Address (If in the latest Address (If in the latest Address (If in the latest Address Address Address Address Address Address (If in the latest Address Address Address Address Address Address Address Address (If in the latest  | named above, and positive identification is to be mailed):  Pess (If information is to be mailed):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | be Released (Mark all that ap  Abstract of Key Reports  Laboratory Reports  X-Ray/Imaging Reports  Complete Acute Care Chart | ss):  pply):  Imaging Films/Studies  Other: |  |  |
| Address (If in the Address in the Ad | named above, and positive identification is to be mailed):  Pess (If information is to | be Released (Mark all that ap  Abstract of Key Reports  Laboratory Reports  X-Ray/Imaging Reports  Complete Acute Care Chart | ss):  pply):  Imaging Films/Studies  Other: |  |  |

Time:

Request Received: Date:\_\_\_\_

MR#

| When Information is Needed:                                                   | ☐ As Soon as Possible                                                    | ☐ By a Specific Date: _                                                  |                                                                                                                                                         |
|-------------------------------------------------------------------------------|--------------------------------------------------------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| (This information is gathered to prioritize reques                            | sts and attempt to meet custom                                           | ner needs. It does <u>not guarantee</u>                                  | e that CRMC can meet all requested timeframes.)                                                                                                         |
| This Authorization Will Expire (                                              | <b>On:</b> /                                                             | or Upon:Specific Event                                                   |                                                                                                                                                         |
| *If not indicated above, this autho                                           |                                                                          |                                                                          |                                                                                                                                                         |
| described above. I understand permitted under state or federal                | that I have a right to<br>law. I understand that<br>alcohol abuse, menta | o inspect or obtain a<br>at the specific informa<br>al health, Human Imn | confidential health information as<br>copy of my health information as<br>ation to be disclosed <b>may</b> include<br>nunodeficiency Virus (HIV) and/or |
| I understand that information disc<br>be protected by federal privacy re      |                                                                          | al for <b>re-disclosure b</b>                                            | y the recipient and may no longer                                                                                                                       |
| notification to the Privacy Office                                            | <u>er</u> at CRMC. I under                                               | stand that revoking th                                                   | t any time by sending such written<br>his authorization stops any furthen<br>quested in the original authorization.                                     |
| •                                                                             | hether I provide autho                                                   | orization for this reque                                                 | nt, payment, enrollment in a health<br>ested use or disclosure, unless it is                                                                            |
|                                                                               |                                                                          |                                                                          | and postage involved in copying<br>er notify you or send an invoice if                                                                                  |
| X                                                                             |                                                                          |                                                                          | Current Date:/                                                                                                                                          |
| PATIENT SIGNATURE (or Person **NOTE: If the patient is represented by another | er person, please include a de<br>r example, a Durable Power of          | scription of your legal authority<br>f Attorney for Health Care is su    | to act for the individual and (if applicable) attach                                                                                                    |
| If Patient is Unable to Sign, Sta                                             | te Reason:                                                               |                                                                          |                                                                                                                                                         |
| Relationship to Patient: 🔲 Se                                                 | elf 🔲 Other:                                                             |                                                                          |                                                                                                                                                         |
| If the CRMC staff need more info<br>how may we contact you?                   | rmation to process thi                                                   | s request or need to c                                                   | ontact you regarding fees,                                                                                                                              |
| Daytime Phone #:                                                              |                                                                          | Other Means:                                                             |                                                                                                                                                         |
|                                                                               | - — — · For CRM                                                          | C Use Only · — — —                                                       |                                                                                                                                                         |
| Identification: □ Driver's License #_                                         |                                                                          | State:                                                                   |                                                                                                                                                         |
| ☐ Other, specify:                                                             |                                                                          | <del> </del>                                                             |                                                                                                                                                         |

Release Completed by: \_\_\_\_\_\_ Date: \_\_\_\_\_