

**AUTHORIZATION AND REQUEST FOR RELEASE
OF CONFIDENTIAL HEALTH INFORMATION**

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 Requesting Release of Information:

- Patient
- Patient's Personal representative ******(See note on last page.)
- Physician, Hospital or Other Health Care Provider
- Health Plan or Insurance Company
- Patient's Attorney
- Other: Specify _____

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

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

Address (If information is to be mailed): _____

Email Address (If information is to be accessed by web-based access):
 _____ @ _____

Fax Number (If information is is Able to be Faxed:) (_____) _____

Please Describe the Information to be Released (Mark all that apply):

Medical Records:	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Abstract of Key Reports	<input type="checkbox"/> Imaging Films/Studies
	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Other: _____
	<input type="checkbox"/> Consultations	<input type="checkbox"/> X-Ray/Imaging Reports	_____
	<input type="checkbox"/> Operative Reports	<input type="checkbox"/> Complete Acute Care Chart	_____
Billing Records:	<input type="checkbox"/> Detail Bill/Itemized Statement	<input type="checkbox"/> Other: _____	
	<input type="checkbox"/> Copy of Statement	_____	
Other Records:	<input type="checkbox"/> Home Health Care Records ; specify: _____		
	<input type="checkbox"/> Cancer Center Records ; specify: _____		
	<input type="checkbox"/> Occupational Health Records ; specify: _____		

For the Following Date(s) of Service: _____

