AUTHORIZATION TO RELEASE INFORMATION (Attachment A)

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Date of Birth: _____ Telephone No.: _____

Medical Record #: _____ SS#: _____

Highpoint Health with Ascension Saint Thomas
Release of Information
Phone 615.328.6623
Fax 615.328.5588 or 615.328.6637

Release of Information FROM Highpoint Health with Ascension Saint Thomas

I authorize **Highpoint Health with Ascension Saint Thomas** to release copies of my records as listed below. The information should be sent to:

_____
Name of Physician, Institution, Self (who the records are going to)

_____
Address

_____ _____
City/St/Zip Phone

DATES OF TREATMENT

Dates: _____

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

Release of Information TO Highpoint Health with Ascension Saint Thomas

I authorize the release of information from:

_____
Name of Physician, Institution (where records are coming from)

_____ _____
Phone Fax

Please send the requested records to:

Dr. _____

Phone: _____ Fax: _____

Floor/Nurses Station Phone: _____

Floor/ Nurses Station Fax: _____

***Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Highpoint Health with Ascension Saint Thomas.**

Information to be Released

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-ray
- ☐ Clinic Visits
- ☐ ER Records
- ☐ EKG
- ☐ Lab
- ☐ Physician Orders
- ☐ **Sensitive** (alcohol, drug, mental illness HIV/AIDs, STD)

Purpose of Release

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of Care
- ☐ Workmen's Compensation
- ☐ Other (Please Specify Below)
- ☐ Disability
- ☐ Insurance
- ☐ Deposition
- ☐ Billing

_____

Expiration date for expressed authorization is _____. If the patient does not express a desire for a specific date or condition to revoke their authorization, this authorization will expire ninety (90) days from the date signed by the patient or legal representative.

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

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

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the Privacy Officer of **Highpoint Health with Ascension Saint Thomas** This revocation document must contain the signature of the patient or patient's legal representative. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

_____ _____
Signature of Patient or Appropriate Legal Representative Date

_____
If applicable, relationship to patient

Photo ID was provided _____yes _____no If no, the form of patient identification must be so stated and a copy provided with the authorization

In order to be valid, the signature on the authorization must be after the date of service that is being requested for release.

_____ _____
Witness Date