Nashville General Hospital

Authorization to Release Health Information

I, _____, hereby authorize Nashville General Hospital (the "Hospital") to disclose health information regarding the following patient:

Patient Name:_____ Date of Birth: _____
Address: _____ Patient's Phone: _____
_____ Social Security No.:_____
Phone: _____ Date of Death: _____

1. The information is to be disclosed to the following persons or organizations:
Name: _____
Address: _____
_____

2. Purpose. The purpose of the use or disclosure is:

☐ At the request of the patient

☐ Other:

_____
_____

If the purpose is for marketing, will the Hospital receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? ☐ YES ☐ NO

3. Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around _____ *(insert dates)*:

☐ The following medical records:

☐ Discharge summary	☐ Progress notes
☐ Lab results	☐ Photographs, videotapes, or other images
☐ History and physical exam	☐ Mental or behavioral health records
☐ Consultation reports	☐ Psychotherapy notes
☐ X-ray reports	☐ Genetic test results
☐ HIV/AIDS test results and treatment	☐ Entire medical record
☐ Treatment plan	☐ Admission notes
☐ Alcohol and drug treatment records	☐ Summary of treatment
☐ Other (specify): _____	
_____	

☐ The following billing and payment information:

_____
_____

☐ Other information: _____
_____

4. Revocation. I understand that I may revoke this authorization at any time by sending a written notice to the Hospital. However, the revocation will not have any effect on any uses or disclosures the Hospital may have made before the revocation was received.

5. Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire six (6) calendar months after the date this authorization is signed.

6. <u>Redisclosure</u>. I understand that information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

7. <u>Refusal to Sign</u>. I understand that I may refuse to sign this Authorization and that the Hospital will not condition treatment on whether I sign this Authorization.

8. <u>Certification</u>. I certify that I am *(check whichever applies)*:

☐ the patient, and the identification that I have provided is true and correct.

☐ the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: ______________________.

Signed this _____ day of ____________, 200__.

Signature: ___________________________________
Print name: ___________________________________
Address: ___________________________________
____
Phone No: ___________________________________

Witness: ____________________________
Print Name: ____________________________
Date: ____________________________

(ONE COPY TO BE RETAINED BY THE PATIENT)

_ _

For Hospital Use Only:

Date received: ____________________ Expiration date: _________________

How was identity verified? _____________________________________ Copy made? ☐ Yes ☐ No
How was authority verified?: ____________________________________ Copy made? ☐ Yes ☐ No

By: ______________________ Title: _______________________ Date: ______________

Nashville General Hospital

CHECKLIST OF REQUIRED ELEMENTS
FOR THIRD-PARTY AUTHORIZATION FORM

Patient name: _____ Disclosure requested by: _____

(This checklist should be completed by Hospital personnel and attached to the third-party authorization to show that the authorization contains the core elements required by the HIPAA privacy regulations.)
The third-party authorization includes all of the following:

☐ A description of the requested protected health information or class of protected health information, including dates of treatment if known. The description must be sufficiently detailed to allow Hospital personnel to determine what information or class of information is being requested.

☐ The name or description of the person, entity, or classes of entities who are being asked to disclose the information.

☐ The name or description of the person, entity, or classes of entities to whom the information is to be disclosed.

☐ A description of the purpose(s) of the use or disclosure. (Note: If the patient initiated the authorization, it is sufficient for the description to say, "At the request of the individual." If the purpose is for marketing, the authorization must indicate whether the Hospital will be paid.)

☐ A date when the authorization will expire, or a description of a relevant event that will cause the authorization to expire.

☐ A statement that the patient has the right to revoke the authorization in writing and instructions on how to revoke the authorization.

☐ A statement that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing the authorization, or a description of the consequences to the patient if he or she refuses to sign the authorization.

☐ A statement that once the information is used or disclosed, it may be subject to redisclosure and may no longer be protected.

☐ The signature of the patient or the patient's authorized representative, and the date signed.

☐ If the authorization is signed by the patient's representative, a description of the representative's relationship and authority to act for the patient.

Date authorization was received: _____

Date authorization was signed: _____ Expiration date: _____

Is the third-party authorization acceptable? ☐ Yes ☐ No

Checklist completed by: _____ Title: _____

How was identity verified? _____ Copy made? ☐ Yes ☐ No

How was authority verified?: _____ Copy made? ☐ Yes ☐ No