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 one year (365 days) after the date this authorization is signed.

Nashville General Hospital

6. Redisclosure. 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. Refusal to Sign. I understand that I may refuse to sign this Authorzation and that the Hospital will not condition treatment on whether I sign this Authorization.

8. Certification. 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 ____________, __.

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: ______________