RHEA MEDICAL CENTER

The Right Care…Right Here
9400 Rhea County Highway, Dayton, TN 37321
PH# 423-775-1121

Please Fax to: ____________

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ________________ **Account Number:** ______________ **MR#:** _____________
Address: ____
City: ___________________ **State:** _______ **Zip:** ___________
Date of Birth: ____________ **Gender:** ____ **Age:** ______ **Primary Care Physician:**______________

I AUTHORIZE RHEA MEDICAL CENTER TO RELEASE COPIES OF THE INFORMATION SELECTED BELOW FOR THE TIME PERIOD LISTED BELOW:

INFORMATION TO BE RELEASED

- ☐ Complete Medical Record
- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ Pathology Report
- ☐ X-ray
- ☐ Clinic visits
- ☐ Emergency Record
- ☐ EKG
- ☐ Lab
- ☐ MD Office Records
- ☐ Other ______________

DATES OF TREATMENT

Which dates of treatment do you need records for?
Dates:____

I AUTHORIZE RHEA MEDICAL CENTER TO RELEASE THE SELECTED INFORMATION TO THE PARTY LISTED BELOW FOR THE PURPOSE(S) SELECTED BELOW:

____
Name of Physician, Institution, etc.
____
Address: ____
City: ______________________________ State: ____ Zip: _____

Please send information requested below to:
Dr. ______________________________
Dept/Clinic: ______________________

PURPOSE OF AUTHORIZATION

- ☐ Attorney
- ☐ Social Security
- ☐ Continued Care
- ☐ Workmen's Comp
- ☐ Disability
- ☐ Insurance
- ☐ Billing/Claims Payment
- ☐ Other ______________

	Initial one
Substance Use Disorder Information. I understand that if my records contain substance use disorder information, such records are protected by federal law and will not be included unless I consent. I understand that substance use disorder information may be contained throughout my records and that my consent is needed to fully release the categories identified above. Information will be disclosed to the person identified above.	___Include ___Do Not Include
HIV/AIDS Information. I understand that if my records contain information in reference to HIV/AIDS (Acquired Immunodeficiency Syndrome) testing and/or treatment that I have been afforded the opportunity to sign a specific authorization.	___Include ___Do Not Include
Mental Health Records. I understand that my medical record may also include information on diagnosis/treatment related to my mental health, psychiatric or psychological conditions	___Include ___Do Not Include

AUTHORIZATION:

I hereby authorize and instruct Rhea Medical Center to use, disclose, and release the protected health information listed above to the party identified above. By signing below, I acknowledge, agree, and understand the following:

- **Right to Revoke**. Except to the extent action has already been taken in reliance on this Authorization, I can, at any time, revoke (take back) this Authorization by submitting a notice in writing to the HIM Department at Rhea Medical Center at 9400 Rhea County Highway, Dayton, TN 37321.
- **Expiration Date**. Unless revoked, this authorization will expire 90 days from the date signed by the patient or legally authorized agent.
- **Re-Disclosure**. Information used and/or disclosed pursuant to this Authorization will not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and some information may also be re-disclosed by the recipient, unless otherwise prohibited by law.
- **Not Required**. I understand that my treatment, payment, enrollment, or eligibility of benefits will not be conditioned on my signing this Authorization.

I have read (or have had read to me) the above statements and understand them as they apply to me. I understand that by signing this form, I am authorizing the use and/or disclosure of confidential protected health information. I understand that this Authorization is voluntary, that the information to be disclosed is protected by law, and that the use/disclosure is to be made to conform to my directions.

____ ____
Signature **Date**

If you have signed as the legally authorized representative of the individual identified above, please provide supporting documentation and complete the following:

Legally Authorized Representative Name (Printed): ____
Relationship to Patient:____
Description of Authority to Act for Patient: ____