Release of Information Policies

To assist in properly handling your request for health information, please **fill out the entire authorization/release form.** Incomplete forms may delay processing of your request.

All requests for copies of Records will be processed on **Wednesday** and mailed to the address indicated on the Authorization to Release Information Form. Older records have been transferred to storage and will take longer to locate and copy.

All authorizations must be dated **after** discharge and **signed by the patient,** unless he/she is a minor, deceased, physically and/or mentally impaired or has appointed Healthcare Power of Attorney or legal guardian. A copy of the Durable Healthcare Power of Attorney or Guardianship documentation must accompany the request.

The standard fee for copies of medical records is:

Pages 1-10	**$0.45 per page**
Pages 11+	**$0.22 per page**

If your written request for health information has not already been filled out and submitted, please complete the authorization/release form and have your identification and all applicable documentation available. We are happy to assist you with any questions.

Please make checks payable to ScanSTAT Technologies.

Authorization to Release Information

<u>Instructions</u>: This form Allows the Release of Information about a Recipient of Services under Title 33, Tennessee Code Annotated, and the Privacy Notice required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended. I understand this Authorization is Voluntary, and the information used or disclosed may be subject to re-disclosure by the person or facility receiving it, and no longer protected by Federal Privacy Regulations (HIPAA).

I,____/___________________________________, authorize
(Print name of service recipient) (Print date of birth)

____/____
(Facility Releasing Protected Health Information) (Address)

To disclose to__________________________________ /____
(Print name of person(s) or organization to which disclosure is to be made, and their mailing address)

The following information:____
(Describe the specific information to be used or disclosed)

The purpose of the authorized disclosure is to: ____
(Specific purpose/use of the disclosure)

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. X_______(Initial) If not applicable, check here. _______

I understand that I Am Not Required to Sign this Authorization, and that my treatment, payment, enrollment, or eligibility for benefits, is Not Conditioned on my Execution of this Authorization. I may Revoke this Consent in Writing at Any Time, Except to the extent that Action has been Taken in Reliance on it, and that, in any event, this Consent Expires Automatically as follows: ______________________________ (Specify the date, event, or condition of expiration)

X____ X_______________________________
(Signature of service recipient who is 16 years of age or older) (Date)

Phone Number: ____________________________

(All blanks <u>must</u> be filled in before signing)
Signature of individual acting on behalf of the service recipient if the individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian-ad-litem of the service recipient but only for the purposes of the litigation in which the guardian-ad-litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased recipient; and (6) the treatment review committee, acting within the authority and scope of §33-6-107, Tennessee Code Annotated.** ***The signature of any individual other than a parent of a child is insufficient to permit release of information unless the individual intending to act on behalf of the individual produces proof of her or his authority to act on behalf of the service recipient.

X____ X_______________________________
***(Signature of individual acting on behalf of the service recipient) (Date)**

<u>YOU MAY REFUSE TO SIGN THIS AUTHORIZATION</u>
****If a service recipient gives oral consent or signs with an X, the form must be signed by two (2) witnesses:**

X____ X_______________________________
****(Witness) (Date) **(Witness) (Date)**

Revised 8/26/2014