Blount Memorial Hospital
907 East Lamar Alexander Parkway
Maryville, TN 37804-5016 865-983-7211

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Place Patient Label Here

Printed Name of Patient _____ **Previous Names, If applicable** _____

Date of Birth _____ **Daytime Telephone Number** _____

SEND INFORMATION TO: (please be specific)

Provider Name/Organization: _____

Address: _____

_____

Phone #_____ Fax #_____

INFORMATION TO BE RELEASED FROM: (please be specific)

Provider Name/Organization: _____

Address: _____

_____

Phone #_____ Fax #_____

PURPOSE OF DISCLOSURE: (please state)

Continued Treatment Processing/Application of Insurance/Benefits Legal

Other: _____

INFORMATION TO BE REQUESTED: (please circle)

INPATIENT OUTPATIENT SDS ER RECORDS

Other: _____

Facesheet	X-ray Records	ER Records
History and Physical	Other diagnostic testing results	Complete Hospital Record
Consultation	Physician Progress Notes	Other Reports: _____
laboratory Reports	Discharge Summary	_____

Covering the period of treatment from: _____

I understand that the medical record may contain information relating to psychological/psychiatric conditions, alcohol,or drug abuse, and/or AIDS testing or testing for the HIV antibody or antigen or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits. I further understand that I am not giving my permission for any re-disclosure other than specified above. I understand that if my protected health information is disclosed by someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would not longer be protected. I hereby waive and release the above named hospital, physician(s), and any member of their staff from any restriction or privilege imposed by law in disclosing or revealing any professional record, observation or communication.

This authorization is subject to revocation at any time except to the extent that the releasing party has already taken action on it. The revocation must be in writing and delivered to the Health Information Management Department. If not previously revoked, this authorization will terminate 90 days from the date of my signature.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain further treatment from Blount Memorial Hosital, nor will it affect my eligibility of benefits.

_____ _____
Signature of patient or authorized legal representative Date

_____ _____
Relationship Witness