Military/Veteran

Blount Memorial Employee

Police/Fire/EMS

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

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Printed Name of Patient ____________________ **Date of Birth** ____________________

Email Address ____________________ **Daytime Telephone Number** ____________________

Please circle: Hospital Records ETMG/BMPG Records

RELEASE/SEND INFORMATION TO: (Please choose one)

_____ Patient

_____ Other (patient must put this person's name and information in the section below)

_____ Power of Attorney for Healthcare (POA) (must show proof)

NAME OF POA: ____________________ DOB: __________ Phone: ____________________

or, if to provider, other healthcare organization, any other entity, or other designee -please fill in below:

Provider Name/Organization: ____________________

Address: ____________________

Phone #: ____________________ Fax #: ____________________

PURPOSE OF DISCLOSURE: (please circle)

Continued Treatment Processing/Application of Insurance/Benefits Legal

Other: ____________________

INFORMATION TO BE REQUESTED: (please circle)

Admission Sheet	Radiology Report	Complete Record	Consultation
Discharge Summary	Laboratory Report	Progress Notes	Therapy Note
History and Physical	Other diagnostic test	ER Record	Itemized Billing

Other Reports: ____________________

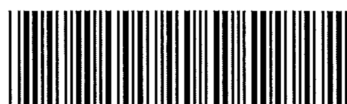
Covering the period of treatment from: ____________________

I understand that the medical record may contain information relating to psychological/psychiatric conditions, alcohol or drug abuse, HIV/AIDS testing or antigen or genetic testing and that 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 (PHI) 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 no 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 (HIM/Medical Records). If not previously revoked, this authorization will terminate 90 days from the date of my signature.

____________________ ____________________
Signature of patient or authorization legal representative Date

____________________ ____________________
Relationship (if not patient) Witness



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Office Use ONLY

Req ID ____________________ Encounter # ____________________