Hamilton County, Tennessee, Government

Authorization to Disclose Protected Health Information ("PHI")

Office Use Only
Date Rcvd:_____ Rcvd. Office: _____
Rcvd. Via (circle one): US-Mail Email HC-Mail Fax
No. Pages Rcvd:_____ Expiration Date: _____
Processed by: _____
Forwarded To
Office/Person: _____
Forwarded Via (circle one): HC-Mail Email Fax
Date Forwarded: _____
Notes: _____

1) This *Authorization* permits release of protected health information ("PHI") for:

Patient's Name: _____ Date of Birth: _____ (MM/DD/YYYY)
(First Middle Last)
All Previous Last Name(s): _____ Last Four Digits of SSN: _____

Current Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ (Include area code) ☐ *Check this box if we may leave you messages at this number.*
Home Phone: _____ (Include area code) ☐ *Check this box if we may leave you messages at this number.*

If we may contact you about this *Authorization* by email, please provide your email address here: _____

2) By initialing *in my own handwriting in blue or other colored ink* on each line below, I certify my understanding that:

_____ This *Authorization* is a three-page document, and is ***ineffective unless pages 1 and 2 are received simultaneously*** and all required sections are appropriately completed. In accordance with HIPAA law, applicable Hamilton County Government departments will keep this *Authorization* on file for a period of six (6) years.

_____ I understand that if I submit this form by fax: (a) see page 3 for listing of department fax numbers; and (b) because HIPAA requires a provider to verify the identity of the requester, Hamilton County Government may require me to verify my identity by phone.

_____ The information disclosed pursuant to this *Authorization* may be subject to re-disclosure by the Recipient and may no longer be protected by applicable federal and state law.

_____ I may refuse to sign this *Authorization* for any reason and no department, division or office of Hamilton County Government may condition my treatment or access to services on whether I sign this *Authorization* unless my treatment is research related or I am to receive healthcare solely for the purpose of creating protected health information for disclosure to the Recipient identified in Section 8.

_____ I have the right to revoke this *Authorization* in writing at any time. The revocation will be effective immediately upon Hamilton County Government's receipt of such revocation, except to the extent that Hamilton County Government acted in reliance on this *Authorization* before written notice of revocation was received. To be effective, revocation must be made in writing and sent to the department, office or division selected in Section 4, below.

_____ If no end date is provided in Section 6, this *Authorization* will expire twelve (12) months from the date signed in Section 11.

_____ If any Hamilton County Government department initiates the release of my records by requesting that I complete this *Authorization,* I will receive a copy of this signed form. I have the right to request such copy if it is not provided.

3) Purpose of disclosure. Check all that apply: ☐ Continuation of Care ☐ Personal Use ☐ Litigation ☐ Other: _____

4) Records are to be released *from* the following: **Check *only* one.**

☐ Hamilton County Health Department ☐ Hamilton County EMS ☐ Hamilton County EMS Billing ☐ Other _____

Name of Organization: _____ Phone Number: _____ (Include area code)

5) The following records are authorized to be released. *In your own handwriting in blue or other colored ink* initial next to each category of records being requested:

_____ Itemized Billing Statements	_____ Medical Record*	_____ Dental Records
_____ Ambulance Run Report	_____ Case Management Records	_____ FMLA Records
_____ Immunization Records	_____ WIC (Women, Infants & Children)	_____ Other: _____

This only includes records from the department's designated record set. Dental, WIC, and Case Management records may also be released when specifically requested. This does not include records concerning highly confidential information (HCI). See Section 7 for release of highly confidential information.

6) Dates of records requested. Specific treatment date(s) or period requested: beginning date: _____ (MM/DD/YYYY) through ending date:* _____ (MM/DD/YYYY)

Ending date may not be a date beyond the date this Authorization is signed. Requests for records beyond this date require a new authorization signed by the patient.

Patient's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY) **Last Four Digits of SSN:** _____

7) Release of highly confidential information ("HCI"). To release any HCI, the requester ***must initial in their own handwriting*** both the following statement ***and*** beside each HCI category authorized to be released. Categories ***not*** initialed will ***not*** be released.

_____ **By initialing any of the HCI categories below, I specifically authorize the disclosure of that HCI category**.

_____ Mental Health
_____ Alcohol & Substance Abuse
_____ Family Planning/Contraceptive Care
_____ HIV/AIDS Testing or Treatment*
_____ Sexually Transmitted Infection (STI)

Including the fact that an HIV/AIDS test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative.

8) Records are to be released *to* the following: Check only one.

☐ Patient or Patient's (select *one*): ☐ Medical Provider ☐ Spouse ☐ Parent of Patient under 18 years of age ☐ Family Member

☐ Attorney ☐ Personal Representative, Guardian Ad Litem, etc. ☐ Business/Employer ☐ Other: _____

Name of Recipient/Provider/Organization: _____ Phone Number: _____ (Include area code)

9) Provide records in the format selected below. Check only one.

☐ Printed copies mailed to Patient at address provided in Section 1. ☐ Sent by encrypted email to: _____

☐ Printed copies mailed to: Address: _____ City: _____ State: _____ Zip: _____

☐ Printed copies to be picked up in person* by (select one): ☐ Patient or ☐ Recipient identified in Section 8. ***Valid photo ID is required for pick-up.***

10) Verification of identity. HIPAA requires that Hamilton County Government verify the identity of anyone requesting protected health information. (45 CFR §164.514(h)). **I am submitting this *Authorization* by** (select ***one***):

If selecting "in person," you must bring ***originals*** of the verification documents you select in Section A-2 or B-2 below.

☐ **In person at a Hamilton County Government Office listed on page 3**.

☐ **US Mail or email**. You must submit ***clear, readable color copies*** of the verification documents you select in Section A-2 or B-2 below.

☐ **Fax**. The verification documents you select in Section A-2 or B-2 below must be ***clear and readable*** and ***received with*** this *Authorization.*

Who is making this request? Select ***only one*** from ***either*** List A or B below, then complete the rest of the corresponding section.

List A. If you select one of the following, complete Section A-2.

☐ Patient, requesting my own records.
☐ Natural parent of Patient under 18 years of age.

Section A-2. Provide a clear color copy of the back and front of a ***current photo ID*** from the following list. Select ***one*** of the following:

State issued: ☐ Driver's License ☐ Photo ID ☐ Handgun Permit
US Government issued: ☐ Military ID ☐ Passport
☐ Form I-766, EAD (Employment Authorization Document)
☐ US Certificate of Naturalization/Citizenship or Citizenship ID card
☐ Other: _____

☐ **I do not have a current photo ID and cannot come into a Hamilton County Government Office**. I am requesting that you attempt to verify my identity by phone using the phone number I listed in Section 1. **Read and initial the following statement**:

_____ I understand that for a period of 30 calendar days after receiving this *Authorization,* Hamilton County Government will attempt to contact me as I have indicated in Section 1 at least three (3) times during normal business hours. If I cannot be reached, and have not provided the documents I selected in Section A-2, this *Authorization* will expire at the end of this 30-day period.

List B. If you select one of the following, complete Section B-2.

Legal guardian of Patient: ☐ under ☐ over 18 years of age
☐ Legal representative ☐ Executor of estate
☐ Adoptive parent ☐ Attorney representing Patient

Section B-2. Provide a clear color copy of the back and front of a ***current photo ID*** from the following list. Select ***one*** of the following:

State issued: ☐ Driver's License ☐ Photo ID ☐ Handgun Permit
US Government issued: ☐ Military ID ☐ Passport
☐ Form I-766, EAD (Employment Authorization Document)
☐ US Certificate of Naturalization/Citizenship or Citizenship ID card
☐ Other: _____

In addition to your photo ID, provide ***one*** of the following.

Certified copy of: ☐ Power of Attorney* ☐ Letters Testamentary*
☐ Court Order* ☐ Death Certificate ☐ Birth Certificate

****Must list the name of the person identified in the photo ID, and the name of the person whose records are being requested.***

11) Authorization signature. Read the following statement, then sign and date ***in your own handwriting in blue or other colored ink.***

I have read and understand the terms of this *Authorization*, and I hereby knowingly and voluntarily authorize Hamilton County Government, specifically the department I have selected above (in Section 4), to disclose my personal health information ("PHI") as I selected above (in Sections 5 and 7), for the purpose(s) I noted (in Section 3). Pursuant to 28 U.S. Code § 1746, I hereby declare under penalty of perjury that I am either the Patient, who is the subject of the requested records, or such Patient's authorized representative, as I have indicated above in Section 8.

Requester's signature: _____

Date: _____ (MM/DD/YYYY) Time: _____ (Include AM or PM)

OFFICE USE ONLY. I, _____, an employee in the _____ department of Hamilton County Government, by my signature below confirm that this *Authorization* was: (1) **completed in my presence**; or (2) the **Requester's identity was verified by me**, via the appropriate method(s) as I have indicated, or per my notation(s), in Section 10, on the date I have entered below.

Employee Signature: _____

Date: _____ (MM/DD/YYYY) Time: _____ (Include AM or PM)

Print your name & department on the first 2 lines. Sign and date in colored ink.

Patient's Name: _____ **Date of Birth:** _____ (MM/DD/YYYY) **Last Four Digits of SSN:** _____

Instructions for Submitting Your Completed Authorization Form

Checklist and Special Instructions. Use this list to ensure you have provided all required information and to provide us with special instructions.

- ☐ Make sure you have provided a phone number in Section 1 in the event we have questions and need to contact you.
- ☐ If we may contact you by voicemail message or email, make sure you have checked the appropriate box(es) and/or provided your email address in Section 1.
- ☐ Make sure to have read and initialed *in your own handwriting in blue or other colored ink* each statement in Section 2.
- ☐ Make sure all initials and signatures are *in your own handwriting in blue or other colored ink*.
- ☐ Make sure you have completed Section 9, providing an address to which the released records should be sent.
- ☐ If requesting release of highly confidential information (HCI), make sure that you have initialed *in your own handwriting in blue or other colored ink* the statement in Section 7 and initialed all HCI categories authorized to be released.
- ☐ If you are not the patient and are requesting release of records as the patient's parent, guardian, legal representative, etc., make sure you have attached a legible copy of documents that give you authority to act on the patient's behalf.
- ☐ If you have any special instructions about how we release your records, please complete the following section and submit this page with your completed authorization form. Please note that we reserve the right to decline to follow instructions that violate any applicable state or federal laws or Hamilton County Government policies.

I hereby request that Hamilton County Government provide my protected health information subject to the following special instructions:

_____

_____

_____

_____

How to Submit Your Completed *Authorization* or a Notice of Revocation of Authorization by U.S. Mail or Email: Your *Authorization* or a *Notice of Revocation* must be ***signed in your own handwriting***. These may be sent by U.S. Mail or email to the department, division or office you noted in Section 4 at the address listed below. Please submit a ***separate form for each department*** from which you wish to receive records or to which you are providing a Notice of Revocation.

Hamilton County Emergency Medical Services (EMS)
317 Oak Street
Chattanooga, TN 37403
***Email**: EMSMedicalRecords@HamiltonTN.gov*
Phone: 423-209-6900
Fax: 423-209-6902

Hamilton County Ambulance Billing
455 North Highland Park
Chattanooga, TN 37404
***Email:** AmbulanceBilling@HamiltonTN.gov*
*Phone**:** 423-209-6366*
Fax: 423-209-6399

Hamilton County Health Department
921 East Third Street
Chattanooga, TN 37403
***Email**: HDMedicalRecords@HamiltonTN.gov*
Phone: 423-209-8209
Fax: 423-209-8210

Other:
Angela Duncan, CHPS, RHIA, HIPAA Officer
Hamilton County Risk Management Department
317 Oak Street, 2nd Floor
Chattanooga, TN 37403
***Email**: AngelaD@HamiltonTN.gov*
Phone: 423-209-6135