Hamilton County, Tennessee, Government

HIPAA Authorization to Disclose Protected Health Information

Office Use Only

Date Rcvd: ____________
Rcvd.(select one): US Mail Email HC-Mail/Email
No. of Pages Rcvd. ____________
Expiration Date: ____________
Processed by: ____________

Forwarded to Appropriate Office

Rcvd. By/Date: ____________
Rcvd.(select one): US Mail Email
Forwarded to/on: ____________
____

1) This *Authorization* permits the release and use of the personal health information ("PHI") of:

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

Address: ____________ City: ____________ State: ____________ Zip: ____________

Cell Phone: ____________ (Include area code) Home Phone: ____________ (Include area code) Can we leave voicemail messages about this *Authorization?* Check all that apply: ☐ On my cell phone ☐ On my home phone ☐ No messages

2) By initialing *in blue ink* on each line below, I certify that 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. HIPAA requires Hamilton County to keep this *Authorization* on file for a period of six years.

_______ Hamilton County Government departments can only accept faxed copies of this *Authorization* from a medical provider. If not a medical provider, I must submit the original document or an electronic copy via email. ***All signatures and initials must be in blue or other colored ink; signatures and initials in black ink will be rejected***.

_______ 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 2.

_______ I have the right to revoke this *Authorization* in writing at any time. The revocation will be effective immediately upon Hamilton County's receipt of such revocation, except to the extent that Hamilton County 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 departments, office or divisions selected in Section 7, below.

_______ If no end date is provided in Section 6, this *Authorization* will expire twelve (12) months from the date signed in Section 10.

_______ If a 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) The PHI of the individual identified in Section 1, above, is hereby authorized to be released to (check 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 or Organization: ____________ Phone Number: ____________ (Include area code)

4) Records to be provided electronically or in printed format.

☐ Electronically, sent by encrypted email to: ____________

☐ Printed copies mailed to Patient at address listed under Section 1. ***Note: Records sent to Patient can only be sent to the address provided under Section 1.***

☐ 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 2. ***Note: Identification may be required to pick-up printed copies of records.***

5) Purpose of disclosure is (check all that apply): ☐ Continuation of Care ☐ Specialist Treatment ☐ Personal Use ☐ Litigation ☐ Billing Claims Payment ☐ Other: ____________

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.***

7) Records are to be released from the following Hamilton County Government departments. Check *only* one:

☐ Health Department ☐ Risk Management ☐ Ambulance Billing
☐ Emergency Medical Services (EMS) ☐ Human Resources ☐ Other: ____________

8) The following records are authorized to be released. Please initial *in blue ink* next to each applicable category of records:

________	Itemized Billing Statements	________	Homeless Health Clinic Records	________	Entire Medical Record*
________	Ambulance Run Report	________	Case Management Records	________	Other: ________________
________	Immunization Records	________	WIC (Women, Infants & Children)	________	Other: ________________
________	Family Medical Leave Act Records	________	Dental Records	________	Other: ________________

****This does not include records concerning highly confidential information.***

9) Release of highly confidential information ("HCI"). In order to authorize the release of any HCI, the requestor ***must initial in blue ink*** next to the following statement:

________ By initialing any of the boxes next to a category of HCI listed below, I specifically authorize the disclosure of the category of HCI indicated next to my initials.

Please initial *in blue ink* next to each applicable category of HCI. If no box is initialed, no information will be released for any purpose.

________	Mental Illness or Disability	________	Sexually Transmitted Diseases (STDs)	________	Sexual Assault
________	Counseling/Mental Health Notes	________	Substance Abuse or Addiction	________	Abuse of an Elderly or Disabled Adult
________	Child Abuse and Neglect	________	Abortion	________	HIV/AIDS Testing or Treatment*

****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.***

10) Authorization signatures. Please read the following statement and complete the appropriate signature line(s) ***in blue ink***.

I have read and understand the terms of this *Authorization*, and I hereby knowingly and voluntarily authorize Hamilton County General Government, specifically the department I have selected in Section 7, above, to disclose my personal health information ("PHI") as I selected above in Sections 8 and 9, for the purpose(s) I noted in Section 5. 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 below.

Signature of:

Patient: ______________________________ Date: ______________ (MM/DD/YYYY) Time: __________ (Include AM or PM)

Authorized Representative: ______________________________ Date: ______________ (MM/DD/YYYY) Time: __________ (Include AM or PM)

Indicate Relationship to Patient: ☐ Parent of Patient under 18 years of age ☐ Legal Guardian* ☐ Court Order* ☐ Estate Executor*

☐ Legal Representative/Power of Attorney* ☐ Other: ____________________ ****Related legal documentation must be attached.***

11) This section will be completed by a Hamilton County employee when this *Authorization* is filled out on site at a Hamilton County Government office.

I, ____________________, an employee Hamilton of County in the ____________________ department by my signature below confirm that this *Authorization* was completed in my presence, on the date I have noted below, and that the Patient's or Requester's identity was verified by me, via the method(s) I have indicated below.

Request by Patient. *Photo ID must be current.*

☐ State-Issued Driver's License
☐ State-Issued Photo ID
☐ Signature verified against existing departmental records
☐ Military Photo ID
☐ Passport with Photo
Other: ____________________

Request by Patient – No Photo ID Presented

☐ Two identifiers—phone number, date of birth, address, last four digits of SSN—verified against existing departmental records.

Other: ____________________

Request by Parent, Legal Guardian or Legal Representative. ***Requestor must provide one item from list A and B. IDs must be current.***

List A – Choose One

☐ State-Issued Driver's License
☐ State-Issued Photo ID
☐ Signature verified against existing departmental records
☐ Military Photo ID
☐ Passport with Photo

Other: ____________________

List B – Choose One

☐ County Attorney's Office approved legal documents (Power of Attorney, Court Order, Letters Testamentary, etc.)
☐ Health Insurance Card – Verified minor covered under parent's health insurance.
☐ Birth Certificate or Order of Adoption listing parent identified in photo ID as minor's parent.

Other: ____________________

Employee Signature: ______________________________ Date: ______________

<u>Instructions for Submitting Your Completed Authorization Form</u>

<u>Checklist and Special Instructions</u>. Use this list to ensure you've 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.
- ☐ Make sure that you have read and initialed each statement in Section 2.
- ☐ Make sure all initials and signatures are in blue or other colored ink. Remember, signatures in black ink will be rejected.
- ☐ Make sure you have completed Section 4, providing an address to which the released records should be sent.
- ☐ If requesting release of highly confidential information, make sure that you have initialed the statement in Section 9 and initialed at least one box.
- ☐ If you are not the patient and 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.

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

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<u>How to Submit Your Completed *Authorization* or Notice of Revocation of Authorization by U.S. Mail or Email</u>: Your *Authorization* or *Notice of Revocation* must be ***<u>signed in blue or other colored ink</u>*** (signatures in black ink will be rejected) may be sent by U.S. Mail to the departments, divisions or offices you noted in Section 6 at the address listed below. Please submit a ***<u>separate form for each department</u>*** from which you wish to receive records.

Hamilton County Health Department
921 East Third Street
Chattanooga, TN 37403
Email*: HDMedicalRecords@HamiltonTN.gov*

Hamilton County Risk Management
317 Oak Street
Chattanooga, TN 37403
Email*: JudithS@HamiltonTN.gov*

Hamilton County Human Resources
317 Oak Street
Chattanooga, TN 37403
Email*: ShelleyK@HamiltonTN.gov*

Hamilton County Emergency Medical Services (EMS)
317 Oak Street
Chattanooga, TN 37403
Email*: EMSMedicalRecords@HamiltonTN.gov*

Hamilton County Ambulance Billing
455 North Highland Park
Chattanooga, TN 37404
Email*: AmbulanceBilling@HamiltonTN.gov*

Other:
Hamilton County Attorney's Office
625 Georgia Avenue, Suite 204
Chattanooga, TN 37402
Attn: Dana M. Beltramo
Email*: DBeltramo@HamiltonTN.gov*