



Nashville Health Information Management Service Center (HSC) - Release of Information
525 Metroplex Drive, Nashville Tennessee 37211

Phone: 615.695.8700 Toll Free: 1-866-270-2311

Please return to fax number 615-916-2208

Section A: This section must be completed for all Authorizations					
Patient Name:		Birth Date:		Social Security No. (optional):	
Provider's Name:		Recipient's Name:		Recipient's Phone:	
Provider's Address:		Address:			
Patient Email:		City:		State:	Zip:
This authorization will expire on the following: (Fill in the Date or the Event but not both.) Date: _____ Event: _____					
Purpose of disclosure:					
Description of information to be used or disclosed					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
Hospital to Release records from:					
<input type="checkbox"/> Skyline Medical Center – Madison Campus		<input type="checkbox"/> Parkridge Medical Center		<input type="checkbox"/> Centennial Medical Center	
<input type="checkbox"/> Skyline Medical Center		<input type="checkbox"/> Parkridge East Medical Center		<input type="checkbox"/> CMC Ashland City	
<input type="checkbox"/> Greenview Regional Hospital		<input type="checkbox"/> Southern Hills Medical Center		<input type="checkbox"/> Parkridge Valley Medical Ctr	
<input type="checkbox"/> Hendersonville Medical Center		<input type="checkbox"/> StoneCrest Medical Center			
<input type="checkbox"/> Horizon Medical Center		<input type="checkbox"/> Summit Medical Center			
Description:	Date(s):	Description:	Date(s):	Description:	Date(s):
<input type="checkbox"/> All PHI in medical record		<input type="checkbox"/> Operative Information		<input type="checkbox"/> Labor/delivery sum.	
<input type="checkbox"/> Admission form		<input type="checkbox"/> Cath lab		<input type="checkbox"/> OB nursing assess	
<input type="checkbox"/> Dictation reports		<input type="checkbox"/> Special test/therapy		<input type="checkbox"/> Postpartum flow sheet	
<input type="checkbox"/> Physician orders		<input type="checkbox"/> Rhythm Strips		<input type="checkbox"/> Itemized bill:	
<input type="checkbox"/> Intake/outtake		<input type="checkbox"/> Nursing Information		<input type="checkbox"/> UB-92:	
<input type="checkbox"/> Clinical Test		<input type="checkbox"/> Transfer forms		<input type="checkbox"/> Other:	
<input type="checkbox"/> Medication Sheets		<input type="checkbox"/> ER Information		<input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not applicable, check here. <input type="checkbox"/>					
I understand that:					
1. I may refuse to sign this authorization and that it is strictly voluntary.					
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.					
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.					
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.					
5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.					
6. I get a copy of this form after I sign it.					
Section B: Is the request of PHI for the purpose of marketing?					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe:					
Section C: Signatures					
I have read the above and authorize the disclosure of the protected health information as stated.					
Signature of Patient/Patient's Representative:				Date:	
Print Name of Patient's Representative:				Relationship to Patient:	



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**HCA SHARED SERVICES CENTER
525 METROPLEX DRIVE
NASHVILLE, TN 37211**

HealthPort contracts with **HCA** to process requests for copies of medical records. The release of patient medical information is governed under Federal and Tennessee state statutes.

The following must be presented:

- A completed authorization (all sections of the authorization must be completed for records to be released)

What we will provide at no cost to you:

- Records to your physician for continuing care. Pertinent information (an abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records will be mailed to you and the following fees will apply based on Tennessee Code Annotated 68-11-304(a)(2). If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

Please notify me if the cost of my records exceeds \$ _____

.25 per page + applicable tax and postage cost

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from **HealthPort**.

PLEASE PRINT:

NAME: _____ PHONE #: () _____

ADDRESS: _____
Street City State Zip

SIGNATURE: _____ DATE: _____