AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Chattanooga-Hamilton County Health Department
921 East Third Street, Chattanooga, TN 37403
Phone: (423) 209-8209 Fax: (423) 209-8210

PATIENT'S NAME ______________________________ **BIRTHDATE** ____/____/______

ADDRESS ____
Street **City** **State** **Zip Code**

HOME PHONE: ______________________ **CELL PHONE:** ______________________

SEND INFORMATION TO: (please be specific)

Name/Organization ______________________________

Address ______________________________

INFORMATION TO BE RELEASED FROM: (please be specific)

Name/Organization ______________________________

Address ______________________________

PURPOSE OF RELEASE:

[ ] Continuation of Care [ ] Specialist [ ] Personal Use [ ] Other ______________

INFORMATION TO BE RELEASED:

[ ] Medical Record from last two years
[ ] Complete Medical Record
[ ] Immunization Record only
[ ] Other______________________
[ ] Release records for the following dates: From______________ To______________

Expiration date for expressed authorization is__________. If a specific date or event is not specified, this authorization will expire six months from the date signed by the patient or legal representative. I understand that I may revoke this authorization in writing at any time, providing the information has not already been released. I understand my treatment at this facility is not based on signing this authorization. I understand that once the information is released per my instructions, the information is subject to redisclosure and may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature______________________________ **Date** ______________

Printed name: ______________________________

Relationship to patient (if other than patient)______________ **Witness** ______________

RELEASE REQUIRING SPECIFIC AUTHORIZATION:

My signature below authorizes the release of any information relating to the testing, diagnosis, and treatment for:

[ ]HIV/AIDS [ ] Sexually Transmitted Diseases [ ] Mental Health
[ ] Substance Abuse [ ] Family Planning/Contraceptive Care

Signature______________________________ **Date** ______________

Printed name: ______________________________

Relationship to patient (if other than patient)______________ **Witness** ______________