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: _____

Hamilton County, Tennessee, Government

HIPAA Authorization to Disclose Protected Health Information

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) The above individual's PHI is hereby authorized to be released to (check one):

☐ Patient ☐ Patient's Attorney ☐ Patient's Personal Representative, Guardian Ad Litem, etc. ☐ Patient's Medical Provider ☐ Spouse

☐ Family Member ☐ Business/Employer ☐ Other: _____

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

3) 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.*

4) Purpose of disclosure is (check all that apply): ☐ Continuation of Care ☐ Specialist Treatment ☐ Personal Use ☐ Litigation

☐ Billing Claims Payment ☐ Other: _____

5) 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. If ending date is left blank, the presumed period will be 12-months from the beginning date.*

6) Records are to be released from the following Hamilton County Government departments, divisions or offices (check all that apply):

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

7) The following records are authorized to be released (***initial*** next to all that apply):

_____ Itemized Billing Statements	_____ Family Medical Leave Act Records	_____ Other: _____
_____ Ambulance Run Report	_____ Homeless Health Clinic Records	_____ Other: _____
_____ Immunization Records	_____ Entire Medical Record*	_____ Other: _____

**This does not include records concerning highly confidential information. See Section 8 below for release of highly confidential information.*

8) Release of highly confidential information ("HCI"). In order to authorize the release of any HCI, the requestor ***must initial*** 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 the box.

Please initial next to all categories of HCI that apply. If no category is initialed, no information will be released for any purpose.

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

9) By initialing each line below, I certify my understanding that:

_____ This *Authorization* is a three-page document, and is ***ineffective unless pages 1and 2 are received simultaneously*** and all required sections are appropriately completed.

_____ I understand that Hamilton County General Government departments, divisions and offices cannot accept a faxed copy of this document. I must provide the original document or an electronic copy via email. ***All signatures must be in blue or other colored ink; signatures in black ink will be rejected***.

_____ The information disclosed pursuant to this *Authorization* may be subject to redisclosure 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 General 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 of this *Authorization.*

_____ 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 6, above.

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

I have read and understand the terms of this *Authorization*, and I hereby knowingly and voluntarily authorize Hamilton County General Government, specifically the departments, divisions and/or offices I have selected in Section 6, above, to disclose my personal health information as I selected above in Sections 7 and 8, for the purpose(s) I noted in Section 4. 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 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*

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

11) This section only applies if this *Authorization* is completed in-person at Hamilton County General Government office:

I, _____, an employee Hamilton of County in the _____ department, division or office, 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 Requestor'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, 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: _____

Signature, Hamilton County employee: _____ Date: _____ (MM/DD/YYYY) Time: _____ (Include AM or PM)

Instructions for Submitting Your Completed Authorization Form

Checklist and Special Instructions. Use this list to ensure you've included 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 you have completed Section 3, 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 8 and initialed at least one box.
- ☐ Make sure that you have read and initialed each statement in Section 9.
- ☐ 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*.

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

_____

_____

_____

_____

How to Submit Your Completed *Authorization* or Notice of Revocation of Authorization by U.S. Mail or Email:

Your *Authorization* or *Notice of Revocation* ***signed in blue or other colored ink*** (signatures in black ink will not be accepted) 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 separate form for each department 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: AMiller@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