Hamilton County Government, Tennessee

Joint Medical/Case Management Records Request Form

Office Use Only
Date Rcvd:____________ Dept:__________________
No. Pages Rcvd:______ Expiration Date: ____________
Processed by: ______________________________
Notes: ________________________________

To release medical records from any Hamilton County Government ("HCG") Covered Entity Component ("CEC"), all sections of this form must be fully completed. Sections 5, 7, *and* 10, 11, *or* 12 must be initialed and signed by the person with legal authority to make this request. Electronic signatures are not permitted. Please print clearly.

1) I authorize release of the following patient's medical record:

Patient's Current Full Name: ____________ (First) ____________ (Middle) ____________ (Last) Date of Birth: ____________ (MM/DD/YYYY)

List Any/All Previous Name(s): ____________ (First) ____________ (Middle) ____________ (Last) Last Four Digits of SSN: ____________

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

Cell Phone: ____________ (Include area code) __________ ***Initial if we may leave you messages at this number.*** Home Phone: ____________ (Include area code) __________ ***Initial if we may leave you messages at this number.***

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

If the Patient is deceased, please provide the patient's date of death: ____________ (MM/DD/YYYY)

2) Important information about your request for records.

- We have 30 days, from the date we receive your request, to respond.
- The **Hamilton County Government ("HCG") Covered Entity Component ("CEC"),** chosen in Section 4 will keep this *Authorization* on file for six (6) years from the date it is received.
- E-Mails from the CEC are encrypted and will be delivered to you from *noreply@securemail.encrypttitan.net.*
- HIPAA permits HCG to require the use of its form for records requests. HCG reserves this right and asks that you complete its form when making a request for records.
- Medical records released by a CEC could be re-disclosed by the person receiving them and may no longer be protected by HIPAA or Part 2.
- You may refuse to sign this *Authorization* for any reason. If you refuse to sign this authorization, it will not affect your treatment, payment, enrollment, or eligibility for benefits.
- This *Authorization* expires ____________ (Expiration Date/End Date). This is one (1) year from the date signed in Section 10, 11, *or* 12. Subsequent records may be released to the person listed in Section 8 for up to one (1) year from the date signed in Section 10, 11, or 12, only by indicating End Date in Section 6.
- You have the right to cancel (revoke) this *Authorization* at any time. Your cancellation (revocation) must be in writing and must be sent to the CEC selected in Section 4. Cancellation of this Authorization will begin immediately when the CEC receives it; however, it will not apply to information that has already been released.
- You have the right to request a copy of this medical records request form with your permissions.
- Additional information about your rights can be found in HCG's Joint Notice of Privacy Practices.

3) Purpose of release. (*Select One*): ☐ Continuation of Care ☐ Personal Use ☐ Law Enforcement ☐ Coroners/Medical Examiners

☐ Legal/Judicial/Administrative Proceedings* (Separate request/may not be combined) ☐ Other: ____________

4) Medical record is to be released *from* the HCG CEC/Other Healthcare Provider selected below. This form is used by multiple CECs, please *choose which applies:*

☐ Health Department ☐ EMS ☐ EMS Billing ☐ Drug Court ☐ Mental Health Court ☐ Veterans Court ☐ Alternative Sentencing

☐ Other Healthcare Provider: ____________ (To request medical records from non-HCG providers) Phone Number: ____________ (Include area code)

5) Person with legal authority. Initial or check beside the record that you are requesting.

_________ Medical Record* _________ WIC (Women, Infants & Children) _________ Immunization Record Only _________ Itemized Billing Statements

_________ Dental Record _________ Case Management Record _________ Ambulance Run Report _________ Other: ____________

_________ Psychotherapy/Substance Use Disorder Counseling Notes** - No other records above may be selected with this request. A separate form is required.

**** Includes immunization record but does not include Dental, WIC, or Case Management records; these must be specifically requested in Other. See Section 7 to give permission to release highly confidential information.***

***** These records for deceased patients require consent from an executor, administrator, or personal representative (T.C.A. § 33-3-105) named in Section 11 or by Court Order (T.C.A. § 33-3-105).***

6) Dates to be released. Please be specific. Specific treatment date(s)/period to be released: Beginning date: ____________ (MM/DD/YYYY) through End/Current date: ____________ (MM/DD/YYYY)

7) Person with legal authority. For highly confidential information ("HCI"), *you must initial in your own handwriting* (do *not* check) *each category* that you give permission to be released. Categories *not initialed* in Section 7 by the patient, where the patient signed Section 10, will *not* be released.

______ Family Planning/Contraceptive Care ______ STI (Sexually Transmitted Infection) ______ HIV/AIDS Testing/Treatment ______ Alcohol/Substance Use Disorder/Part 2 Records

8) Medical record is to be released *to* the following:

By:

☐ Pick up in person
☐ Mail
☐ Fax
☐ E-Mail

☐ **Patient in Section 1** or ☐ Person/Place below:

Person/Place: ____________
Address: ____________
City: ____________ State: ____________ Zip Code: ____________
Phone: ____________ (Include area code) Fax: ____________ (Include area code)
Email Address: ____________

9) Verification. Required documents are listed in the Sections 10, 11, and 12.

- **"Pick-up in person"** you must bring **originals** of the verification documents when you bring your completed form to the County to obtain the requested records.
- **"US Mail or email"** you must submit ***clear, readable color copies*** of the required verification documents, which must be ***received with*** this completed Authorization.
- **"Fax"** you must submit ***clear and readable*** verification documents, which must be ***received with*** this completed Authorization.

Complete *only one* section below (Section 10, 11, *or* 12), depending on your legal authority. Please note: At this time, we do not have capability to verify the validity of an electronic signature facilitated and provided by an outside entity; therefore, electronic signatures are not permitted.

Patient's Name: ______________ (First) ______________ (Middle) ______________ (Last) **Date of Birth:** ______________ (MM/DD/YYYY)

10) Person with legal authority. If you are the ☐ **Patient and the information below is the same as Section 1, skip 10.A. and complete only 10.B. and 10.C., or if you are the ☐ Patient's Parent, complete all of Section 10. If you are not the patient or the patient's parent, please go to section 11. Electronic signatures are not permitted.**

A) Demographic Information.

Requester's Full Name: ______________ (First) ______________ (Middle) ______________ (Last) Date of Birth: ______________ (MM/DD/YYYY)

Current Address: ______________ City: ______________ State: ______________ Zip: ______________

Cell Phone: ______________ (Include area code) ______ *Initial if we may leave you messages at this number.* Home Phone: ______________ (Include area code) ______ *Initial if we may leave you messages at this number.*

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

B) Verification Process. HIPAA requires the CEC to verify the identity of anyone requesting a patient's medical record.

→ Provide a clear color copy, ***front and back***, of your ***current state- or government-issued photo ID*** from only one the following:

State-Issued: ☐ Driver's License/Handgun Permit ☐ Photo ID

Government-Issued: ☐ Military ID ☐ Passport ☐ Form 1-766, EAD (Employment Authorization Document)

☐ US Certificate of Naturalization/Citizenship or Citizenship ID Card ☐ Other: ______________

C) Signature.

Person with legal authority: Read the following statement, then ***in your own handwriting*** sign, provide your relationship to the patient, and date. **Your signature here must match the signature on your State- or Government-issued identification. Signatures that do not match will not be accepted, and your request for medical records will be denied.**

Pursuant to 28 U.S. Code § 1746, I hereby declare under penalty of perjury that I am either the patient authorizing disclosure of my medical record, or I am the patient's parent as I have indicated above.

Signature: ______________ Relationship to Patient: ______________ Date: ______________ (MM/DD/YYYY)

If you are the patient or the patient's parent and signed above, your Authorization is complete. Please submit pages 1and 2, along with the required documents chosen above to the CEC chosen in Section 4.

11) Person with legal authority. Complete this section *only* if you are the patient's: ☐ **Legal Guardian** ☐ **DCS** ☐ **Executor of Estate** ☐ **Administrator**

☐ **Legal Personal Representative (other than attorney) -** ***Attorneys see Section 12*** ☐ **Other:** ______________

A) Demographic Information.

Requester's Full Name: ______________ (First) ______________ (Middle) ______________ (Last) Date of Birth: ______________ (MM/DD/YYYY)

Current Address: ______________ City: ______________ State: ______________ Zip: ______________

Cell Phone: ______________ (Include area code) ______ *Initial if we may leave you messages at this number.* Home Phone: ______________ (Include area code) ______ *Initial if we may leave you messages at this number.*

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

B) Verification Process. HIPAA requires the CEC to verify the identity of anyone requesting a patient's medical record.

→ Provide a clear color copy, ***front and back***, of a ***current state- or government-issued photo ID*** from only one the following:

State-Issued: ☐ Driver's License/Handgun Permit ☐ Photo ID

Government-Issued: ☐ Military ID ☐ Passport ☐ Form 1-766, EAD (Employment Authorization Document)

☐ US Certificate of Naturalization/Citizenship or Citizenship ID Card ☐ Other: ______________

→ ***In addition*** to a ***current state- or government-issued photo ID*** provide a clear color copy of one of the following: ***Must list the name of the person identified in the photo ID and the name of the person whose medical record is being requested.**

☐ Power of Attorney* ☐ Letters Testamentary* ☐ Court Order* ☐ CS-0206 ☐ Death Certificate ☐ Birth Certificate

C) Signature.

Person with legal authority: Read the following statement, then ***in your own handwriting*** sign, provide your relationship to the patient, and date. **Your signature here must match the signature on your State- or Government-issued identification. Signatures that do not match will not be accepted, and your request for medical records will be denied. Electronic signatures are not permitted.**

Pursuant to 28 U.S. Code § 1746, I hereby declare under penalty of perjury that I am the patient's authorized representative, as I have indicated above.

Signature: ______________ Relationship to Patient: ______________ Date: ______________ (MM/DD/YYYY)

If you are the patient's non-attorney, as indicated above, your Authorization is complete. Please submit pages 1 and 2, along with the required documents chosen above, to the CEC chosen in Section 4.

HAMILTON COUNTY GOVERNMENT OFFICE USE ONLY.

I, ______________ (Print Your Name), an employee in the ______________ (CEC Name), by my signature below confirm that this *Authorization* was:

(A) ______ (Initials) **Completed in my presence and the requester's identity was verified by me**; or

(B) ______ (Initials) **Requester's identity was verified by me**, via the appropriate method(s) indicated above or per my note: ______________

(C) ______ (Initials) **I processed and completed this request for medical records.**

Employee Signature: ______________ Date: ______________ (MM/DD/YYYY)

Interpreter Signature: ______________ Date: ______________ (MM/DD/YYYY)

Patient's Name: ______________________________ **Date of Birth:** ____________
First Middle Last MM/DD/YYYY

12) Attorney with legal authority. This section is to be completed by Attorneys *only*. Select and complete A, B *or* C, and D below.

Please Note: At this time, we are not able to verify the validity of an electronic signature obtained and provided by an outside entity; therefore, electronic signatures are not permitted. Providing incomplete information or an electronic signature *will* result in your request being rejected. Court/case information will be verified. *HCG reserve the right to reject documents that fail to establish an attorney's authority to obtain PHI to include "highly confidential information" such as Part 2 records.*

Pursuant to 45 CFR § 164.541(h) **Hamilton County is *required* to verify the identity of the person requesting PHI.** Therefore:

A) As permitted by HIPAA, Hamilton County Covered Entity Components ("CEC") will ***only*** accept this form, completed by the patient or the patient's representative, as outlined in Sections 10 and 11 above, **or by an Attorney**, who is (**select 1, 2 or 3**):

(1) ☐ the Patient's duly appointed Guardian or Conservator, where the attorney provides a *properly executed and registered* **Power of Attorney.**

(2) ☐ the Appointed Executor, **OR** ☐ representing the duly appointed Executor, of the Patient's estate, where the attorney provides *properly issued* **Letters Testamentary.**

(3) ☐ the Attorney representing the Patient, where the attorney provides the **following information**:

a) Docket No. ______________, in the matter of ______________________ v. ______________

In (select one): ☐ Circuit Court ☐ Chancery Court for ______________ County, TN; or ☐ Other Court: ______________

b) attaches a copy of a generic HIPAA authorization form or other documentation (*i.e.*, contract for professional services or letter of engagement, signed by the attorney's client authorizing the attorney to obtain their medical records and substance use disorder records), and

c) provides a copy of the client's government-issued ID.

B) Alternatively, where Hamilton County is a self-funded plan, pursuant to Hamilton County *Resolution* 679-69, and a covered entity, pursuant to 45 CFR § 160.103, in lieu of, or in conjunction with, this form, Hamilton County will accept a:

☐ **Court Order** that comports with *Tenn. Code Ann.* § 8-27-910. *(See "Notice to Attorneys" at the bottom of this page).*

C) If for valid reason, you are unable to provide any of the above documentation, Hamilton County will accept the following where applicable:

☐ By my signature below, I certify, as an officer of the Court and a duly-licensed attorney, that:

(1) for valid reason, I am unable to provide any of the above documentation; therefore, I am unable to provide a docket number or any of the documents listed in (a) or (b), above; and

(2) I have attached a copy of a generic HIPAA authorization form or other documentation, *i.e.*, contract for professional services or letter of engagement, signed by my client authorizing me to obtain their medical records; witnessed patient sign this form, but no government-issued ID.

B) ***Attorney Signature – Required***. Pursuant to 28 U.S. Code § 1746, I hereby declare under penalty of perjury that, as indicated above, I am the authorized representative of the Patient and have legal authority to obtain the medical records of the Patient identified herein.

Attorney's Printed Name: ______________________ Office Phone: ______________

Mailing Address: ______________________ Email: ______________

Attorney's Signature: ______________________ BPR No. ______________ Date: ______________
MM/DD/YYYY

If you are the patient's attorney, your Authorization is complete. Please submit pages 1 and 3, along with the required documents chosen above, to the CEC selected in Section 4.

Where to Submit your completed Medical Records Request form or Notice of Revocation

A Medical/Case Management Records Request form **or a** ***Notice of Revocation*** may be sent by U.S. Mail or email to the CEC you selected in Section 4 at the address listed below.

Hamilton County Emergency Medical Services (EMS)
3916 Volunteer Drive
Chattanooga, TN 37416-3817
Email: EMSMedicalRecords@HamiltonTN.gov
Phone: 423-209-6900 / Fax: 423-209-6902

Hamilton County Ambulance Billing
455 North Highland Park Avenue
Chattanooga, TN 37404-2016
Email: AmbulanceBilling@HamiltonTN.gov
Phone: 423-209-6363 / Fax: 423-209-6399

Hamilton County Health Department
921 East Third Street
Chattanooga, TN 37403-2102
Email: HDMedicalRecords@HamiltonTN.gov
Phone: 423-209-8209 / Fax: 423-209-8210

Hamilton County HIPAA Privacy Officer
Hamilton County Attorney's Office
625 Georgia Avenue, Room 204
Chattanooga, TN 37402-1956
Email: HIPAA@HamiltonTN.gov
Phone: 1-833-484-8671

Hamilton County Drug Recovery Court
8395 Hickory Valley Road, Chattanooga, TN 37416
Phone: 423-209-7570

Hamilton County Mental Health Court
401 West MLK Blvd, Suite 3035
Chattanooga, TN 37402-1632
Phone: 423-209-6195

Hamilton County Veterans Treatment Court
401 West MLK Blvd, Suite 3035
Chattanooga, TN 37402-1632
Phone: 423-209-6195

Hamilton County Alternative Sentencing
6215 Dayton Blvd, Hixson, TN 37343-2710
Phone: 423-209-8600 / Fax: 423-847-4829

Notice to Attorneys: If you plan to submit a Court Order, whether in lieu of, or in addition to, this form, you may contact the HIPAA Privacy Officer who can assist you in assessing whether your order comports with both HIPAA and *Tenn. Code Ann*. § 8-27-910. Please Note: Court Orders that do not comply with both federal and State law may be subject to a motion to quash, or other legal pleading, as determined appropriate by the Hamilton County Attorney's Office.