1) This Aut	Hamilton County, Tennessee, Government HIPAA Authorization to Disclose Protected Health Information Protected Health Information ("PHI") of: me:	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. (select one): US Mail Email Forwarded to Appropriate Office Rcvd. (select one): US Mail Email Forwarded to/on: Last Four Digits of SSN:
Address:	City:	State: Zip:
Cell Phone:	Home Phone: Can we leave voicemail message Include area code Include area code	s about this <i>Authorization</i> ? Check all that apply: home phone I No messages
2) By initial	ing <u>in blue ink</u> on each line below, I certify that my understanding that:	
	This <i>Authorization</i> is a three-page document, and is <i>ineffective unless pages 1 and 2 are re</i> sections are appropriately completed. HIPAA requires Hamilton County to keep this <i>Authoriza</i> . Hamilton County Government departments can only accept faxed copies of this <i>Authorization</i> .	tion on file for a period of six years.
	provider, I must submit the original document or an electronic copy via email. <u>All signature</u> <u>colored ink; signatures and initials in black ink will be rejected</u> . The information disclosed pursuant to this <i>Authorization</i> may be subject to re-disclosure by the	
	by applicable federal and state law.	
	I may refuse to sign this Authorization for any reason and no department, division or office of Ha my treatment or access to services on whether I sign this Authorization unless my treatment healthcare solely for the purpose of creating protected health information for disclosure to the	nt is research-related or I am to receive
	I have the right to revoke this <i>Authorization</i> in writing at any time. The revocation will be effect receipt of such revocation, except to the extent that Hamilton County acted in reliance on the revocation was received. To be effective, revocation must be made in writing and sent to the description 7, below.	his Authorization before written notice of
	If no end date is provided in Section 6, this Authorization will expire twelve (12) months from the	e date signed in Section 10.
	If a Hamilton County Government department initiates the release of my records by requestir receive a copy of this signed form. I have the right to request such copy if it is not provided.	ig that I complete this Authorization, I will
3) The PHI o	of the individual identified in Section 1, above, is hereby authorized to be released to (che	eck one):
Patient	or Patient's (select <u>one</u>):	18 years of age 🔲 Family Member
Attorney	Personal Representative, Guardian Ad Litem, etc. Dusiness/Employer Other:	
Name of Re	cipient or Organization:	Phone Number:
	to be provided electronically or in printed format.	Include area code
	ically, sent by encrypted email to:	
Printed	copies mailed to Patient at address listed under Section 1. <i>Note: Records sent to Patient can only be</i> copies mailed to: Address: City:	sent to the address provided under Section 1.
Printed	copies to be picked up in person by (select one): Patient or Recipient identified in Section of copies of records.	on 2. Note: Identification may be required to
5) Purpose	of disclosure is (check all that apply): Continuation of Care Specialist Treatment	Personal Use Litigation
Billing C	aims Payment Other:	
	records requested. tment date(s) or period requested: beginning date: through ending da	
*Ending date r	may not be a date beyond the date this Authorization is signed.	MM/DD/YYYY
7) Records	are to be released from the following Hamilton County Government departments. Check	only one:
		ance Billing Page 1 of 3

8)) The following	records are auth	orized to be release	d. Please initial	in blue ink next to	each applica	ble category c	of records:

Itemized Billing Statements Ambulance Run Report Immunization Records Family Medical Leave Act Records	Homeless Health Clinic Records Case Management Records WIC (Women, Infants & Children) Dental Records	Entire Medical Record* Other: Other: Other: Other:		
*This does not include records concerning highly confidential information	1.			
9) Release of highly confidential information ("HCI"). In order the following statement: By initialing any of the boxes next to a ca category of HCI indicated next to my initials.				
Please initial <i>in blue ink</i> next to each applicable category of	f HCI. If no box is initialed, no information	on will be released for any purpose.		
	ally Transmitted Diseases (STDs) tance Abuse or Addiction ion	Sexual Assault Abuse of an Elderly or Disabled Adult HIV/AIDS Testing or Treatment*		
*Including the fact that an HIV/AIDS test was ordered, performed or report	ted, regardless of whether the results of such	tests were positive or negative.		
10) Authorization signatures. Please read the following stater	nent and complete the appropriate sign	ature line(s) <u>in blue ink</u> .		
I have read and understand the terms of this Autho Government, specifically the department I have selected in Sect Sections 8 and 9, for the purpose(s) I noted in Section 5. Pursu the Patient who is the subject of the requested records, or such	tion 7, above, to disclose my personal h ant to 28 U.S. Code § 1746, I hereby d	ealth information ("PHI") as I selected above in eclare under penalty of perjury that I am either		
Signature of: Patient:	Date:	Time:		
	Date	MM/DD/YYYY Include AM or PM		
Authorized Representative:	Date:	MM/DD/YYYY Time: Include AM or PM		
Indicate Relationship to Patient: 🔲 Parent of Patient under	er 18 years of age 🛛 🗌 Legal Guardia			
Legal Representative/Power of Attorney*		*Related legal documentation must be attached.		
11) This section will be completed by a Hamilton County en Government office. I,, an department by my signature below confirm that this Authorization or Requester's identity was verified by me, via the method(s) I h	employee Hamilton of County in the n was completed in my presence, on the			
Request by Patient. Photo ID must be current. State-Issued Driver's License State-Issued Photo ID Signature verified against existing departmental remains Military Photo ID Passport with Photo Other:	Request by Patient – NoTwo identifiers—phonlast four digits of SSNdepartmental records	e number, date of birth, address, —verified against existing		
Request by Parent, Legal Guardian or Legal Repre	esentative. Requestor must provide <u>one ite</u>	m from list A and B. IDs must be <u>current</u> .		
List A – Choose One State-Issued Driver's License State-Issued Photo ID Signature verified against existing departmental reco Military Photo ID Passport with Photo Other:	(Power of Attorney, C Drds Health Insurance C parent's health insu Birth Certificate or (identified in photo II	Diffice approved legal documents ourt Order, Letters Testamentary, etc.) ard – Verified minor covered under rance. Drder of Adoption listing parent D as minor's parent.		
Employee Signature:	Dat	le:		

Instructions for Submitting Your Completed Authorization Form

ecklist and	I Special Instructions . 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:

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