northcrest *health*

NORTHCREST MEDICAL CENTER

Medical Record and/or Account Number: _____ Phone Number: (615) 384-1542

Date(s) of Treatment: _____ Fax Number: (615) 382-3803

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(PLEASE INCLUDE A COPY OF YOUR PHOTO IDENTIFICATION.)

PATIENT IDENTIFICATION:

Name: _____ Date of Birth: _____

Maiden Name or Other Name(s) Known By: _____

Provider: NorthCrest Medical Center

Release Records To: Name: _____

Address: _____

City / State / Zip Code: _____

INFORMATION REQUESTED FROM:

- ❑ Accounting of Disclosure
- ❑ Billing
- ❑ Care Center
- ❑ Emergency Room
- ❑ Home Health
- ❑ Hospital Stay
- ❑ Other Media (films, videos, photos)

TYPE(S) OF INFORMATION REQUESTED:

- ❑ Discharge Summary
- ❑ EKG Report
- ❑ History and Physical
- ❑ Immunization
- ❑ Lab Report
- ❑ Other: _____
- ❑ Nurse's Notes
- ❑ Operative Report
- ❑ Pathology Report
- ❑ Physician's Progress Notes
- ❑ X-Ray Report

PURPOSE OF RELEASE: ❑ Insurance ❑ Medical Care ❑ Requested by Patient ❑ Other: _____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug or alcohol abuse, acquired immune deficiency syndrome, or HIV status. I understand and agree that the information, if any, pertaining to such diagnosis/treatment described above may be released.

REQUIRED: Please initial the statement that applies to you:

___ I ***do*** authorize the release of this information.

___ I ***do not*** authorize the release of this information.

List any limitations concerning the release: _____

TIME LIMIT: I understand this authorization may be revoked, in writing, at any time, except to the extent that action has taken place in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

_____

SIGNATURE OF PATIENT
OR LEGAL REPRESENTATIVE: _____ **Date:** _____

RELATIONSHIP TO PATIENT: _____ **Witness:** _____

PLEASE NOTE: When your medical information is released pursuant to a valid authorization, you should be aware that the information may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. Treatment may not be withheld or conditioned on obtaining this authorization, as is prohibited by the Privacy Rule.