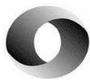 Tanner Medical Center, Inc.

MRN: ________________
(for internal purposes)

Request and Authorization to Disclose and/or Copy Medical Information
(Protected Health Information)

Patient Information (please print):

Patient Name: ______________________ Date of Birth: ______________

Street Address: ______________________ City: ____________ State/Zip: __________

I, ______________________________ ______________________________,
(Patient or legal representative name) ***(Address if different from patient's)***
do hereby authorize Tanner Medical Center, Inc., and all affiliated entities and subsidiaries ("TMC") to disclose information or copies thereof covered under privacy regulations issued pursuant to the HIPAA Act of 1996 pertaining to the patient above to:

Requester Name (Facility Name, Person, Company): ______________________
Address: ______________________ Telephone Number: ______________
E-mail: ______________________ Fax Number: ______________

I authorize the disclosure of Medical Records maintained by TMC pertaining to the care and treatment rendered for date(s) of treatment:

From (date) ________________ through (date) ________________

I authorize medical records to be released from (choose all that apply):

☐ Tanner Medical Center/Carrollton
☐ Tanner Medical Center/Villa Rica
☐ Higgins General Hospital
☐ Tanner Medical Center/East Alabama
☐ Willowbrooke at Tanner (Behavioral Health Facility)
☐ TMG/Clinic Name: ______________________

The information requested and to be disclosed is (choose all that apply):

☐ Demographics
☐ ED/ER Report
☐ History & Physical
☐ Discharge Summary
☐ Consultation Note
☐ Progress Note
☐ Operative Report
☐ Clinician Orders
☐ Laboratory Reports
☐ Cardiac Reports/EKG
☐ Physical Therapy Notes
☐ Respiratory Therapy Notes
☐ Speech Therapy Notes
☐ Occupational Therapy Notes
☐ Financial Record/Bills
☐ Radiology/X-ray Reports
☐ Radiology/X-ray Images (CD/DVD)
☐ Abstract only
☐ Complete Record
☐ Other: ______________

(Federal Regulation 42 CFR) This consent and authorization includes, for the period indicated, the care and treatment records designated pertaining to the patient for physical and/or emotional illness including psychological or psychiatric treatment and/or alcohol and drug abuse, and/or AIDS (HIV) related testing or illness, and/or testing for sexually transmitted diseases.

The requested use or disclosure of this medical information is:

☐ Personal Use ☐ Legal ☐ Insurance ☐ SS/Disability ☐ Continuity of Care ☐ Other: ______________

- I hereby acknowledge and understand that this authorization is a waiver of the confidential and privileged nature of the records designated above but only with respect to the specified purpose(s) for which this disclosure is made.
- I further acknowledge and understand that this authorization will prevent the patient from making claim for a violation of privacy in connection with the release of the medical information as described herein.
- I understand that Tanner Medical Center, Inc. cannot require me to sign this authorization in order to receive treatment unless the provision of healthcare is solely for the purpose of creating PHI for disclosure to a third party (example: employee physical exam) or for research related treatment, in which Tanner Medical Center, Inc will not provide the service unless I sign this authorization.
- This request and authorization may be revoked at any time by written notice received by Tanner Medical Center, Inc's Health Information Management Department, but any revocation will not apply to records already furnished in reliance upon this request and consent.
- This request shall remain valid until revoked, or upon the expiration of sixty (60) days, whichever occurs first.

____
(Signature of patient or legal representative) *(Relationship)* *(Date/Time)* *(Witness)* *(Date/Time)*

____
(Signature of minor patient when required) *(Date/Time)* *(Witness)* *(Date/Time)*

Persons Authorized to Consent to Release of Medical Information	
1. Any adult for self (18 years or older) 2. Any parent for his/her minor child 3. A guardian for his/her ward	4. Next of kin for disabled patient unable to sign for self, or Executor or Administrator of an estate for the sole purpose of obtaining payment for services from a third party payer in connection with an insurance claim.

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