

HCA PHYSICIAN SERVICES

THE FRIST CLINIC

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. <i>(optional)</i> :
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Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):
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PHI Recipient Name:	Address/City/State/Zip	Phone Number: () _____ Fax Number: () _____
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PHI Sender Name:	Address/City/State/Zip	Phone Number: () _____ Fax Number: () _____
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This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: _____ Event: _____

Purpose of Disclosure:

Is this request for psychotherapy notes?

- Yes, then this is the only item you may request on this authorization.
 No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Demographics	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Rehabilitation	
<input type="checkbox"/> Consult Report		<input type="checkbox"/> Imaging/Radiology		Services	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Nursing Notes		<input type="checkbox"/> Special Test/Therapy	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Medication Record		<input type="checkbox"/> Itemized Bill/Claims	
				<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
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Print Name of Patient's Representative:	Relationship to Patient:
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**HEALTH INFORMATION SPECIALISTS
CONTRACTS WITH**

**THE FRIST CLINIC
2400 PATTERSON STREET SUITE 400
NASHVILLE, TN 37203
615-342-5911 (phone) 615-342-5962 (fax)**

TO PROVIDE MEDICAL RECORDS RELEASE OF INFORMATION

Dear Requestor:

Patient requests for records will be billed according to the following fee schedule, plus tax and applicable postage:

\$.50 per page for pages 1-40

\$.25 per page for pages 40+

All other requestors should direct rate inquiries to 615-342-5911.

PLEASE NOTE: Your records will normally be processed within five working days after your request has been received. You may inquire about the status of your request and the total due by calling 615-342-5911.

We are unable to fax or mail medical records to attorneys or insurance companies without a valid authorization directly from that party. We will accept and process requests from attorneys and insurance companies received via U.S. mail once we have verified that the authorization meets State and Federal requirements.

By my signature below, I agree to pay the fee for medical records when an invoice is received from HealthPort.

NAME (Please print): _____

SIGNATURE: _____

**THANK YOU FOR ALLOWING US TO SERVE YOU IN YOUR REQUEST FOR
MEDICAL RECORDS!**