STERN CARDIOVASCULAR FOUNDATION

A Member of BAPTIST Memorial Medical Group

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT'S NAME: ___________________________ BIRTH DATE: ________________ Chart #: ______________

ADDRESS: ______________________________________ Phone #: ___________________ Last 4 digits of SS#: ________

I authorize Stern Cardiovascular Foundation or the following person or organization (specify if applicable) ____________________________

____ to:

☐ **Disclose** my health information to: ____

____

(Name and address) – Specify: Attorney, Insurance, Self, etc.

☐ **Obtain/request** copies of my health information from: ____

____

(Name and address) – Specify: Hospital, Doctor, etc.

Purpose of use, disclosure , and/or disclosed: ☐ Continuation of Care/Treatment ☐ Attorney ☐ At the request of the patient ☐ Payment

☐ Other, specify: ____

I authorize use and/or disclosure of information covering treatment from: ____________________ to: ______________________

(enter specific dates)

Information to be used and/or disclosed:

☐ Abstract of a Visit/Encounter ☐ Office Visit/Progress Note ☐ History and Physical ☐ Lab ☐ Radiology/Imaging ☐ All Records ☐ Itemized Bill

☐ Other, specify: ____

I understand that the disclosure of my personal health information may include information regarding diagnosis and/or treatment for any of the following: alcohol abuse, drug abuse, psychiatric or mental illness, and/or sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or (AIDS virus).

This release will include information I have previously restricted from my health plan unless I initial here. ____________

(Initials)

This authorization will expire one year from the date of your signature unless you specify a difference expiration date, event, or condition:

Please specify: ____

I understand that I have a right to revoke this authorization at any time, except to the extent that release of information has already occurred in reliance on my prior authorization.

I understand that in order to revoke an authorization, a written document stating the intent of the patient is to be either delivered in person or by certified mail to the Director of Health Information Management at Stern Cardiovascular Foundation's main office located at 8060 Wolf River Blvd, Germantown, TN 38138. The revocation document is to contain the signature of the patient or patient's legal representative.

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. Refusal to sign this form will not affect my receipt of treatment. However, if this authorization is for release of records to a third party for payment, enrollment or eligibility of benefits purposes, such as workers' compensation, private health insurance, application for insurance, etc., my refusal to sign may affect payment, enrollment or eligibility for benefits. This, in turn, may affect payment for services I receive and I may become responsible for all charges incurred. I understand that it is my responsibility to inquire with the party requesting my health records regarding the effect of my refusal to sign this form.

I understand that any disclosure carries with it the potential for re-disclosure by the recipient of the information and such re-disclosure may not be protected by federal confidentiality laws.

When Stern Cardiovascular Foundation seeks an authorization for its own use or disclosure of protected health information (e.g., research, etc.), a copy of the authorization is provided to the patient.

______________________________	______________________________
Date	Patient (or person authorized to consent for minor or patient who is unable to sign)
______________________________	______________________________
Witness	Relationship and/or authority to act for the patient

Photo ID was provided: ☐ Yes ☐ No If no, specify form of patient identification: ______________________________

10/30/2014