AUTHORIZATION TO RELEASE INFORMATION TO/FROM RHASA

Patient's Name: _____

Patient's Address: _____

City, State, Zip: _____

Date of Birth: _____ Social Security #: _____

Renaissance Health & Surgical Associates
325 South Cedar Avenue, Suite 2
South Pittsburg, TN 37380
Phone: (423)837-5801 Fax: (423)837-5807

I authorize the release of information TO/FROM RHASA from the entity listed below:

_____
Name of Physician, Institution, Self, etc.

_____
Address

_____
City/State/Zip

(_____)_____-_____ (_____)_____-_____
Phone Number Fax Number

Dates of treatment (which dates of treatment do you need records for?) _____

_____

The information that is to be released should be detailed to specific dates of service, treatment, etc. A meaningful description of the information to be disclosed should be provided.

Information to be released:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Operative Report
- ☐ X-Ray
- ☐ Labs
- ☐ Clinic Visits
- ☐ ER Records
- ☐ HIV Results ___ (initials)
- ☐ Mental Health Records ___ (initials)
- ☐ EKG
- ☐ Physician Orders
- ☐ Other: _____

Purpose of release:

- ☐ Attorney
- ☐ Social Security
- ☐ Continuation of Care
- ☐ Worker's Comp
- ☐ Other: _____
- ☐ Disability
- ☐ Insurance
- ☐ Disposition
- ☐ Billing

Expiration date for expressed authorization is _____. If the patient does not express a desire for a specific date or condition to revoke his/her authorization will expire ninety (90) days from the date signed by the patient or patient's legal representative. I have read, or have had read to me, the above statements, and understand them as they apply to me. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or patient's legal representative is allowable only in the event that release of information has not already occurred. Specific exceptions to revoke an authorization exist, as detailed by federal law, such as:

- RHASA has taken action in reliance on the authorization, or
- The authorization was obtained as a condition of obtaining insurance coverage, whereby another law provides the insurer with the right to contest a claim under the policy.

In order to revoke an authorization, a written document stating the intent of the patient to revoke such authorization must be either presented in person to or delivered by certified mail to the Privacy Officer of RHASA. This revocation document must contain the signature of the patient or patient's legal representative, and that signature must be formally certified by a Notary Public. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization.

Signature of Patient or Patient's Legal Representative: _____ Date: _____

(If a personal representative of the individual signs the authorization, a description of such representative's authority to act on behalf of the individual must be provided.)

Relationship, if not the patient _____

Witness _____

Photo ID was Provided ☐ Yes ☐ No
Date: _____