Authorization for Use or Disclosure of Protected Health Information (Medical Records Release)

(Release/Request)

1. I hereby authorize **State of Franklin Healthcare Associates, PLLC** to [ ] the following information:

Patient Name: _____ **Date of Birth:** _____

Telephone: _____ **Last 4 of SSN: xxx-xx-**_____

2. **Person(s) or Entity Authorized to Receive the Disclosure. Name or specifically describe the persons/organizations (or the classes of persons and/or organizations), including us, (1) who you are authorizing to make use of the protected health information described below and who you are authorizing to disclose the protected health information described below, and (2) to whom you are authorizing the disclosure and subsequent use of the protected health information described below.**

TO:	FROM:
_____ Name of Healthcare Provider/ Other	_____ Name of Healthcare Provider/ Other
_____ Street Address	_____ Street Address
_____ City, State, Zip Code	_____ City, State, Zip Code
_____ _____ Phone Fax	_____ _____ Phone Fax

3. **Protected Health Information to be used or disclosed. Specifically and meaningfully describe the protected health information you are authorizing to be used and/or disclosed:**
   - ☐ My health information relating to the following treatment or condition: _____
   - ☐ My health records for the following date(s):_____
   - ☐ Most recent _____ years of record
   - ☐ Complete health record:
     - ☐ Include: ☐ Exclude: My health information related to psychiatric or psychological conditions or treatment, except psychotherapy notes; alcohol and drug abuse; sickle cell anemia; and acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
   - ☐ Immunization Record
   - ☐ Last Physical
   - ☐ Other information to be used or disclosed (describe information in detail):

4. **Purpose of use or disclosure:**
   - ☐ Treatment, Payment, or Healthcare Operations
   - ☐ Transfer of Care
   - ☐ Personal Use
   - ☐ Disclosure to Life Insurer for Coverage Purposes
   - ☐ Disclosure to Employer of results for pre-employment physical or lab tests
   - ☐ Other (describe each purpose of the requested use/disclosure in detail):

5. **If not previously revoked, this Authorization will expire within 1 year from the date listed or ☐ upon the happening of the following event:** _____.

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Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I have had the opportunity to read and consider the contents of this authorization. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I further understand that refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits. I understand that I may revoke this authorization in writing, except for any actions already taken based upon it. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by federal or state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Patient or Personal Representative: _____ Date: _____

Relationship if Personal Representative: _____

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("***HIPAA***").

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to State of Franklin Healthcare Associates at the following address: Attn: Privacy Officer, 2528 Wesley Street, Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire as indicated on page 1 or within one year from the time the form was signed.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.
5. You may inspect or copy the protected health information to be used or disclosed under this authorization. You do not have the right of access to the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act ("CLIA") prohibits access, or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual in some of these circumstances, an individual has a right to have the denial reviewed by a licensed health care professional designated by the covered entity who did not participate in the original decision to deny.
6. If this office initiated this authorization, you must receive a copy of the signed authorization.
7. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes.*** HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes.
8. You have a right to an accounting of the disclosures of your protected health information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient or Personal Representative MUST receive a copy of this form once completed.

State of Franklin HEALTHCARE ASSOCIATES