PARALLON
BUSINESS SOLUTIONS

Nashville Health Information Management Service Center (HSC) - Release of Information
525 Metroplex Drive, Nashville Tennessee 37211
Phone: 615.695.8700 Toll Free: 1-866-270-2311 Fax 615-916-2208

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Social Security No. *(optional)*:**	
Provider's Name:	**Recipient's Name:**	**Recipient's Phone:**	
Provider's Address:	**Address:**		
Patient Email:	**City:**	**State:**	**Zip:**

This authorization will expire ninety days from the date of signature unless otherwise indicated below.
Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Hospital to Release records from: Check all that apply

☐ Skyline Medical Center – Madison Campus
☐ Skyline Medical Center
☐ Greenview Regional Hospital
☐ Hendersonville Medical Center
☐ Horizon Medical Center
☐ Parkridge Medical Center
☐ Parkridge East Medical Center
☐ Southern Hills Medical Center
☐ StoneCrest Medical Center
☐ Summit Medical Center
☐ Centennial Medical Center
☐ CMC Ashland City
☐ Parkridge Valley Medical Ctr
☐ Terre Haute Regional Medical Ctr

Description: check all that apply	Date(s):	Description: Description: check all that apply	Date(s):	Description: check all that apply	Date(s):
☐ All PHI in medical record		☐ Operative Information		☐ Labor/delivery sum.	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill:	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ 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)

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. 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.
4. 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.
5. 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.
6. I get a copy of this form after I sign it.

Section B: Is the request of PHI for the purpose of marketing?
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

Section C: Signatures

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

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient/Representative:	**Relationship to Patient:**
ROI updated 10/15/12	

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HCA SHARED SERVICES CENTER
525 METROPLEX DRIVE
NASHVILLE, TN 37211

contracts with HealthPort. to process requests for copies of medical records. The release of patient medical information is governed under Federal and Tennessee state statutes.

The following must be presented:

- A completed authorization (all sections of the authorization must be completed for records to be released)

What we will provide at no cost to you:

- Records to your physician for continuing care. Pertinent information (an abstract) for continuing care includes transcribed reports (discharge summary, history and physical, operative reports), radiology reports, lab reports and clinic notes (if applicable). If you would like additional records sent, please specify on the authorization what records are to be sent.
- Page 1 through 5 of your patient records will be provided at no cost

Requests for records to be sent to a third party (attorney, insurance company) can only be completed with a request and authorization directly from that party. If you desire records for this purpose or for your own personal use, the records will be mailed to you and the following fees will apply based on Tennessee Code Annotated 68-11-304(a)(2). If you believe the records you are requesting may exceed a certain dollar amount and would like to be notified of this in advance, please indicate in the area below.

A charge of $ .25 per page + applicable tax and postage cost

Please notify me if the cost of my records exceeds $_____.

By my signature below, I acknowledge that I am aware of the fee for copies of medical records. I agree to pay this fee when I receive an invoice from ***HealthPort.***

PLEASE PRINT:

NAME:_____ PHONE #: (____) _____

ADDRESS:_____
Street City State Zip

SIGNATURE:_____ DATE:_____

10/22/2012

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