	Authorization for Release of Health Information	*For office use only* Medical Record # ________________ ECD # ________________

Please complete all pages of this form, sign, and return by mail or fax.

RELEASE RECORDS FROM: **(Who is releasing information?)**

☐ **T. J. Samson Community Hospital**	☐ **T. J. Health Greensburg Clinic**
☐ **T. J. Health Columbia**	☐ **T. J. Health Home Care Program**
☐ **T. J. Health Pavilion**	☐ **T. J. Health Home Care Program**
☐ **T. J. Health Cave City Clinic**	☐ **T. J. Health Rehab and Sports Medicine**
☐ **T. J. Health Columbia Clinic**	☐ **T. J. Health Russell Springs Clinic**
☐ **T. J. Health Columbia Primary Care**	☐ **T. J. Health Tompkinsville Clinic**
☐ **T. J. Health Edmonton Clinic**	
☐ **T. J. Family Medicine Center**	☐ Specific Provider: ____________________________

PATIENT INDENTIFICATION	Name:____ Date of Birth:__________________ Social Security Number: ____

I request and authorize T. J. Regional Health to release medical information of the patient named above.

RELEASE RECORDS TO: **(How and Where records should be sent?)**

HOW	**WHERE**
☐ Mail ☐ Pick up in person ☐ Fax to Provider ☐ Encrypted Email	Name /Agency: ____ Address: ____ City: ______________________ State: _________ Zip: ______________ Phone #:______________________Cell #: ______________________ Fax #: ______________________**(For Healthcare Providers Only)** E-mail Address: ____

INFORMATION REQUESTED

DATES OF TREATMENT TO BE RELEASED: **Specific Date:** ______________________________

Range of Dates: From ______________________________ To ______________________________

MEDICAL RECORDS ☐ **Abstract of Pertinent Information Only –** ➢ Admission Form, HP, DS, OP Report, Path, Consult, Test Results (Lab, X-ray, Cardiology)	**OR Specific Categories** ☐ History and Physical ☐ Discharge Summary ☐ Operative/Procedure Notes ☐ Pathology Report ☐ Consultations ☐ Lab Results ☐ Radiology Results	☐ Cardiology Reports ☐ Respiratory Reports ☐ Emergency Department ☐ Obstetrics (Labor & Delivery) ☐ Office / Clinic Notes ☐ Other *(specify)*:
OTHER DEPARTMENT	☐ Cardiac Images (ex. Cath/ECHO/ EKG) (*specify*):______________________ ☐ Radiology Images (*specify*): ______________________________ ☐ Neurology Images (*specify*): ______________________________	
PURPOSE OF RELEASE	☐ Further Treatment ☐ Personal Use ☐ Attorney / Legal	☐ Insurance ☐ Other *(specify)*:

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I understand that:

- This authorization covers only treatment prior to the date below. Any requests after this date will need a separate authorization.
- My medical record may include information on diagnosis or treatment related to psychiatric or psychological conditions, drug or alcohol abuse, acquired immune deficiency syndrome (AIDS) or HIV status. I agree that any information about such diagnosis or treatment be released.
- If I do not ask for my legal medical record or specify the records I want, the HIM Dept. will only send an abstract of pertinent information from my legal medical record.
- I may revoke this authorization at any time, by sending a written statement to:

  TJSCH Privacy Officer
  1301 N. Race Street
  Glasgow, KY 42141

  I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Authorizing the disclosure of health information is voluntary. Refusing to sign this authorization will not affect my treatment, payment, enrollment, or eligibility for benefits.
- Information used or disclosed pursuant to the Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility and its employees are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I have read and understand this information and authorize disclosure of the protected health information under the terms stated above.

Signature of Patient: ____ **Date:** __________ **Time:** _______

Signature of Parent/Guardian/Representative: _____________________________ **Date:** __________ **Time:** _______

Relationship to Patient: ☐ **Parent** ☐ **Guardian** ☐ **Power of Attorney** ☐ **Legal Representative**

Proof of designation must be filed in the chart or sent with this request

PLEASE MAIL OR FAX THE COMPLETED AUTHORIZATION FORM TO:

T. J. SAMSON COMMUNITY HOSPITAL
HEALTH INFORMATION MANAGEMENT DEPARTMENT
1301 NORTH RACE ST., GLASGOW, KY 42141

FAX: 270-651-7155

For office use only

Released By: ____ **Date:** ____________ **Time:** ___________

☐ **Picked Up** ☐ **Mailed** ☐ **Faxed** ☐ **Encrypted Email**

☐ **Verified Identification**

Additional Notes:

RELEASE
RELEASE