



## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_  
DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I hereby authorize CHC901 LLC DBA Community Health Care to disclose the information from the above-named patient's record to:

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

2. The purpose(s) of need(s) for which the information is being disclosed (patient request, insurance matters, litigation use, etc.) is/are being made:

3. I authorize the disclosure of the following information from my medical record:

☐ Ambulance Trip Ticket ☐ CHC Billing Statements/Invoices

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral health or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have the right to revoke this authorization at any time by presenting written revocation to the Medical Records Custodian at CHC901 LLC P.O. Box 250, Brunswick, Tennessee 38014, I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. If this authorization has not been revoked, it will terminate on the following date, event or condition:

If I fail to specify an expiration date, event, or condition, this authorization will automatically expire in six (6) months.

6. I understand that I can refuse to sign this authorization. I need not sign this form to obtain, treatment, payment, or health enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient or disclosures of the health information, I can contact Community Health Center Privacy Officer at P.O. Box 250 Brunswick, Tennessee 38014.

Signature of Patient or Personal Representative

Printed Name of Patient or Personal Representative

Date of Signature

Relationship Personal Representative (if not Patient)

State of \_\_\_\_\_ County of \_\_\_\_\_

On this \_\_\_\_ day of, 20\_\_\_\_, before me, the undersigned notary public, appeared

proved to me through satisfactory evidence of \_\_\_\_\_

documents to be the person who signed the above in my presence.

Signature of Notary Public

My commission expires

Notary Seal:

\*\* If the individual signing this form is acting on behalf of the service recipient, the Individual is: (1) the parent, legal guardian, or legal custodian of a service recipient who is under 18 years of age; (2) the conservator or guardian for the service recipient; (3) the guardian ad litem of the service recipient but only for the purposes of the litigation in which the guardian ad litem serves; (4) the attorney-in-fact under a power of attorney who has the right to make disclosures under the power for the service recipient; (5) the executor, administrator, or personal representative on behalf of a deceased service recipient; and (6) the treatment review committee, acting within the authority and scope of Tennessee Code Annotated Section 33-6-107, **Appropriate documentation of proof of this Individual's to act on behalf of the recipient must be submitted to the entity being asked to release information before the information will be released.**

**A death certificate is required for all deceased patient's regardless of the personal representation and purpose for the request to disclose the protected health information.**