AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT:

Name of Patient/Previous Names	**Birth Date/Medial Record Number**
Street Address	**City, State, Zip**

AUTHORIZES: RELEASE OF PROTECTED HEALTH INFORMATION:
By signing this Authorization Form, I understand that I am giving my authorization for ETSU to use and/or disclose my protected health information (PHI) as described in more detail below, to the following person(s) or organization(s):

SEND TO:	**FROM:**
ETSU Center of Excellence for Children in State Custody	
Name of Health Care Provider/Plan/Other	Name of Health Care Provider/Plan/Other
P.O. Box 70567	
Street Address	Street Address
Johnson City, TN 37614	
City, State, Zip Code	City, State, Zip Code

INFORMATION TO BE RELEASED: ENTIRE RECORD _____, or:

_____ Medical History, Examination, Reports	_____ Surgical Reports	_____ Immunizations
_____ Treatment or Tests	_____ Hospital Records (reports, discharge, intake)	_____ X-Ray Reports
_____ Allergy Records	_____ Laboratory Reports	_____ Prescriptions
_____ Consultations	_____ School Information (testing, teacher observations)	

_____ Other (Specify): _____

For the reason below which require special permission to release otherwise privileged information, please release records pertaining to:

_____ Mental health	_____ Developmental Disabilities	_____ Alcoholism
_____ HIV (AIDS)	_____ Sexually Transmitted Disease	_____ Drug Abuse

_____ Other (Specify): _____

For the following date(s): _____

PURPOSE FOR NEED OF DISCLOSURE: (Check applicable categories)

_____ Further Medical Care	_____ Legal Investigation or Action	_____ Coordination of Care
_____ Insurance Eligibility/Benefits	_____ Changing Physicians	_____ Consultation of Care Plan

_____ Other (Specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHT WITH RESPECT TO THIS AUTHORIZATION:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the Office Manger.
Right to Receive Copy of This Authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provide with a signed copy of the form.
Right to Refuse to Sign This Authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. If I am providing authorization for marketing purposes, I understand that ETSU may receive remuneration from a properly authorized business associate as a result of using or disclosing my PHI.
Right to Revoke This Authorization – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Office Manager. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in references to this authorization.

EXPIRATION DATE: This authorization is good until the following date(s) _____ or until the following event occurs:
_____

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately relects my wishes.

SIGNATURE PATIENT/LEGAL REPRESENTATIVE: _____ **DATE**: _____
Witness _____ (*If signed by other than patient, state relationship and authority to do so.)*