Parallon Ciox Release Of Information -Authorization Form

Nashville HIM Service Center Release of Information
PO Box 290429, Nashville TN, 37229
Phone: 866.270.2311 Fax: 855.901.6104

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Last 4 digits SSN *(optional)*:**
Facility Name:	**Recipient's Name:**	**Recipient's Phone:**
Facility 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:

Request Delivery (If left blank, a paper copy will be provided): ☐Paper Copy ☐ Electronic Media, if available (e.g.,USB drive, CD/DVD) ☐Encrypted Email Unencrypted Email ☐

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

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.

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) If not applicable, check here. ☐

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:**

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