Medical Records Release Authorization Form

Before SpecialtyCare, Inc. can release patient records, we require the attached medical release authorization to be completed and returned. Below are a few helpful tips:

- In the **first set of boxes**. enter the patients name, date of birth, address, etc. This tells us whose records we are providing.
- For "**Persons/Organizations Authorized to Release Information**", you may put SpecialtyCare, Inc. This will capture records from all of the SpecialtyCare, Inc. and its affiliates.
- "**Persons/Organizations to Receive the Information**" is referring to who and where you would like us to send the records. We typically email the records to the individual (or organization if applicable). If you prefer to have the records mailed to you instead, please note that somewhere on the form or in a separate letter/email.
- The **checkboxes** tell us what information is to be released. You may check any or all of the boxes. Check the last box if you only want records from a specific date of service, or a specific type record (such as the final neuromontioring report).
- **Purpose of Disclosure** is self explanitory.
- For **authorization expires**, I would suggest putting a date that is one year in the future. Why? If you enter todays date, the authroization will be expired before we received it and we would have to start this authorization process over again.
- **Event** is often used for legal purposes and can be left blank.

To complete the form, please have the patient sign at the bottom and enter todays date; then print the patients name below their signature. If someone other than the patient signs the form as their representative, that person will have to provide documentation (such as a Power of Attorney) proving that they can legally sign on the patients behalf.

Once the form has been completed, you may return it via emial (medicalrecordrequest@specialtycare.net), by faxing it to 888-959-2219, or by mailing it to the address below. You may do any of these at your convenience. If you have any additional questions, my direct line is 615-345-5551.

SpecialtyCare, Inc.
3 Maryland Farms, Suite 200
Brentwood, TN 37027
Attn: Office of General Counsel.

Thanks.

Sincerely,

Pat

Patricia Falte
Medical Records Coordinator
3 Maryland Farms, Suite 200
Brentwood, TN 37027
615-345-5551
medicalrecordrequest@specialtycare.net

SpecialtyCare
partners for life

Authorization for Disclosure of Protected Health Information
(Not to be used for purposes of marketing or sale of PHI)

Patient Name (print):		Birth Date:	Date of Service:
Street Address:	City	State	Phone number:

Persons/Organizations Authorized to Release Information: _____ (the "Covered Entity")

Persons/Organization to Receive the Information: (the "Recipient")

Name (or title) and organization:			
Address:			
City:		State:	Zip:
Phone:	Fax:	Email:	

I hereby authorize the Covered Entity named above to release the following health information to the Recipient:

☐ All of my health information in the Covered Entity's possession (clinical documentation and billing information)
☐ Clinical Documentation only in the Covered Entity's possession
☐ Billing information only in the Covered Entity's possession
☐ Other (Please describe: may include date restrictions or other limitations)_____

Purpose of Disclosure: _____

Note: "at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose

This authorization will expire on the following: (Fill in date or the Event but not both)

Date: _____ **Event:** _____

My Rights

I understand that:

1. I have the right to revoke this authorization, in writing, at any time. In order to revoke this authorization, I must do so in writing and send it to the appropriate Covered Entity.
2. The revocation will only be effective from the date it is received by the provider and will not apply retroactively. Uses and disclosures already made based upon my original permission cannot be taken back.
3. It is possible that information disclosed based on this authorization may be re-disclosed by the recipient; once disclosed, the information may no longer be protected by the HIPAA Privacy Standards.
4. I understand the Covered Entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
5. I have the right to refuse to sign this authorization.
6. I may receive a copy of this authorization after I have signed it upon request. A copy of this authorization is as valid as the original.

Not for Marketing or Sale

This authorization does not authorize the Covered Entity to sell the information or to use the information for marketing purposes.

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 or Patient's Representative, if applicable:	Relationship to Patient: ☐ Self ☐ Representative (Describe authority and provide documentation):_____ _____

NOTE: IF SIGNED BY A REPRESENTATIVE AND NOT THE PATIENT, THE SIGNED AUTHORIZATION MUST BE ACCOMPANIED BY DOCUMENTATION OF THE REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF THE PATIENT.