HIGH RISK OBSTETRICAL CONSULTANTS, PLLC
1930 ALCOA HIGHWAY BUILDING A, SUITE 435 KNOXVILLE, TN 37920
PHONE: (865) 263-2400 FAX: (865) 263-2441

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

DATE: _____/_____/_____

PRINT PATIENT'S FULL NAME:
_____

PATIENT'S DATE OF BIRTH: ___/____/_____

SOCIAL SECURITY NUMBER:_____-_____-_____

PRINT NAME OF PARENT/LEGAL GUARDIAN:
_____

PHONE: (_____) _____

PATIENT ADDRESS:
_____
_____

THE FOLLOWING INFORMATION IS TO BE RELEASED:

__PRENATAL RECORDS
__GENETICS EVALUATION
__AUTOPSY REPORT
__PATHOLOGY REPORT
__CLINIC NOTES
__LAB RESULTS
__DRUG SCREENS
__OTHER:_____

REASON/PURPOSE FOR DISCLOSURE:
_____
_____

APPLICABLE DATES:
FROM: ___/___/_____ TO: ___/___/_____

RECORDS TO BE RELEASED FROM:	RECORDS TO BE RELEASED TO:
Facility/Doctor Name: _____	Facility/Doctor Name: _____
Phone #:_____	Phone #:_____
Fax #:_____	Fax #: _____

- I place no limitations an history or illness (including HIV and/or AIDS, genetics, drug dependency or psychiatric information) or diagnostic and therapeutic information, including any treatment for alcohol, drug abuse/substance use disorder, or psychiatric disorders.
- I authorize the inspection of the above information by the above-named agency/person and/or to the furnishing of other copies.
- I understand that unless otherwise limited by state or federal regulation, I may withdraw this consent at any time by submitting my withdrawal request in writing. The withdrawal of the authorization does not affect any health information disclosed prior to High Risk Obstetrical Consultants ("HROC") receiving a written notice of withdrawal.
- I hereby release HROC and its members, officers, directors, and employees from any and all liabilities, responsibilities, damages, losses, and claims which might arise from the release of the information authorized above.
- In furthermore of this authorization, I do hereby waive all provisions of the law and privileges related to the disclosures hereby authorized.
- I understand that HROC may not condition treatment, payment, enrollment or eligibility for benefits on whether the I sign this authorization.
- I understand that my records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its related regulations, and (as applicable) federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and my medical records/protected health information cannot be disclosed without my written authorization unless otherwise provided for in the HIPAA or 42 CFR Part 2 regulations. Federal regulations also prohibit any further re-disclosure of this information by the person or organization with which you have consented for us to disclose/exchange information. 42 CFR part 2 prohibits unauthorized disclosure of records related to substance use disorder prevention and/or treatment.
- I hereby acknowledge that I have read (or had someone read to me) the above statements, and I fully understand the above statements, and do expressly and voluntarily authorize the disclosure of this medical information or the individual, entity, or agency named above.

Any disclosure of medical information by the recipient(s) is prohibited except when implicit in the purpose of this authorization.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this authorization expires_____ (insert applicable date or event of "no expiration designated") or in 12 months, whichever is shorter, and no further use / disclosures as described above may be made after the expiration. Authorizations apply only for medical records for specified treatment dates prior to and on the date of signature unless otherwise specified.

Signature:_____ Date:_____

If the person who signed this form is not the patient, describe authority to sign on behalf of patient: _____
_____
_____

INTERNAL USE ONLY
SENT BY: _____ VIA: _____ DATE:_____