GALEN
MEDICAL GROUP

AUTHORIZATION FOR RELEASE USE/ DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

4976 Alpha Lane, Hixson TN 37343 • (423) 899 – 4412 • medical.records@galenmedical.com

Patient Name: _____ Date of Birth: _____

GALEN HAS NOT DETERMINED WHETHER OR NOT INFORMATION CONCERNING THE DIAGNOSIS OR TREATMENT OF SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV OR AIDS, MENTAL HEALTH, AND/OR THE USE OF ALCOHOL, DRUGS, OR TOBACCO MAY BE PRESENT IN THIS MEDICAL RECORD. IF SUCH INFORMATION MAY BE PRESENT IN THE MEDICAL RECORD, THE UNDERSIGNED AUTHORIZES THE RELEASE OF SUCH INFORMATION.

This Authorization is intended to comply with the Health Insurance Portability and Accountability Act (HIPAA) and includes statutes and rules regulated by The Tennessee Code Annotated (TCA) for the release, use and disclosure of medical information, and if applicable, the release, use and disclosure of medical information with respect to minors, incapacitated patients, and deceased persons. The undersigned acknowledges that Galen cannot guarantee information disclosed pursuant to this Authorization may not be re-disclosed by the recipient and/or no longer protected by privacy regulations.

Additionally, the undersigned acknowledges that any previous agreements to limit access to protected health information (PHI) do not apply to this authorization. The undersigned authorizes Galen Medical Group to release and disclose the patient's complete medical record without restriction, except as specified in this authorization.

The undersigned further understands and acknowledges that this authorization is voluntary, and the undersigned is not required to sign this authorization for treatment, payment, enrollment, or eligibility for benefits. This authorization is effective for one year, but may be revoked in writing at any time, except for any actions Galen may have already taken in reliance on this authorization prior to the time of the revocation. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal or state privacy rules and may be shared with others. Upon request, I may receive a copy of this authorization form after I sign it. A photocopy or facsimile of this authorization shall be valid and effective, just as the original.

Service Fees Scan to register for Galen's Patient Portal. →

Patients may access and download their medical records from the patient portal free of charge. To register you can scan the QR code or contact the Patient Portal Helpdesk at (423) 551-4745.

Scan to Register

Galen Medical will provide medical records to other providers outside of Galen Medical for continuation of care at no cost. However, Galen Medical Records may apply charges for the mailing of medical records and/ or any applicable additional fees for resources rendered in compliance with state and federal regulations. Galen will not receive financial or in-kind compensation or remuneration in exchange for the disclosure of the patients protected health information unless an applicable legal exception applies. For questions regarding the payment process or access to medical records please contact the Medical Records Department at medical.records@galenmedical.com or by calling (423) 899 – 4412.

CONSTITUENT OF THE REQUESTED INFORMATION

Requestor Type

- ☐ Myself (Above Named Patient)
- ☐ Legal Guardian/ Power of Attorney
- ☐ 3rd Party with Authorization by Above Named Patient
- ☐ Government Authority
- ☐ Insurance
- ☐ Provider's Office
- ☐ Attorney
- ☐ Other: _____

Purpose of Release

- ☐ Personal
- ☐ Continuation of Care
- ☐ Billing
- ☐ Legal
- ☐ Social Security
- ☐ Insurance
- ☐ Worker's Compensation
- ☐ Disability
- ☐ Diposition
- ☐ Other: _____

Information to be Released

- ☐ Entire Medical Record (Clinical and Billing)
- ☐ Entire Clinical Record
- ☐ Entire Billing Record
- ☐ Specific Information:

☐ Clinic Visits
☐ X-Ray
☐ Operative Report
☐ Discharge Summary

☐ ER Records
☐ Laboratory/ Test
☐ Physicians Orders
☐ History & Physical

(If applicable): _____

Specific Dates of Information to be Released

☐ Specific Dates (If applicable, specify the dates): _____
Date Range: From MMDDYYYY to MMDDYYYY or (if multiple specific dates): MMDDYYYY, MMDDYYYY, MMDDYYYY

☐ Entire Record (Check this box if you need all records.)

Preferred Delivery Method

- ☐ Fax
- ☐ Paper, In-Person Pickup
- ☐ Paper, Certified Mail
- ☐ Other: _____

☐ USB, In-Person Pickup
☐ USB, Certified Mail
☐ Secure Email (Only to direct patient or guardian)

Delivery Location Details

To: [party to whom records will be released] _____

Address: _____

Phone: _____

E-mail: [required only for fax or secure email verification] _____

Fax: [required only for fax or secure email verification] _____

If you are not the patient named above and are not requesting records for yourself, please provide the additional details requested and sign the section below.

REQUESTOR INFORMATION

Requestor's Contact Information

Requestor's Name: _____

Requestor's Position/ Title as Authorized Authority: _____

Requestor's Phone: _____

Requestor's Email: _____

By signing below, as my own personal self-representative, or as the requester of another person's personal health information, I acknowledge and agree that Galen Medical is relying on my legal authority as granted by applicable state or federal law to make this request on behalf of the above-named patient. I certify, under penalties of perjury, that to the best of my knowledge and belief, I am the authorized legal representative and/or possess the legal authority necessary to make this request.

Date Requested: _____

Required for this Authorization to be effective for any portion of the Medical Record.
Signature of patient or patient representative pursuant to the designated authority above.

(Signature Required)