HIPAA=AUTH

Metropolitan Government of Nashville and Davidson County
Authorization to Release Health Information

Member Name:__________________________ Date of Birth: ___________________
Address: _____________________________________ Member's Phone: ________________
_____________________________________ Social Security No.:______________
Phone: _______________________________

I hereby authorize ______________________ (the "Plan") to disclose my health information as described below.

The information is to be disclosed to the following persons or organizations:
Name: ____
Address: ____
____

Purpose. The purpose of the use or disclosure is:

☐ At the request of the member
☐ Other:
____
____

Information to be Disclosed. The information to be disclosed includes only those items checked below, with respect to services provided on or around ______________________ *(insert dates)*:

The following billing and payment information:
____
____
____

Other information:
____
____
____

Expiration. I understand that unless I revoke the authorization earlier, this authorization will automatically expire ____.

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time by sending a written notice to the Plan. However, the revocation will not have any effect on any uses or disclosures the Plan may have made before the revocation was received.

- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).

- Information used or disclosed pursuant to this authorization may no longer be protected by federal law, and could be re-disclosed by the receiving party.

- I have been provided with a copy of this authorization.

- I may refuse to sign this Authorization and that the Plan will not condition treatment on whether I sign this Authorization.

I certify that I am *(check whichever applies)*:

☐ the member, and the identification that I have provided is true and correct.

☐ the member's personal representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the member is that of: ________________________.

A copy, facsimile, or electronic transmission of this signed authorization shall have the same effectiveness as an original.

Signed this _____ day of ____________, 200__.

Signature: ____________________________
Print name:____________________________
Address: ____________________________
____
Phone No:____________________________

Witness: _____________________
Print Name: ___________________
Date: ________________________

(ONE COPY TO BE RETAINED BY THE MEMBER)

_ _

For Plan Use Only:

Date received: ____________________ Expiration date: _________________

How was identity verified? ______________________________ Copy made? ☐ Yes ☐ No
How was authority verified? _____________________________ Copy made? ☐ Yes ☐ No
By: ______________________ Title: ______________________ Date: ______________

For ADA accommodations, contact our Coordinator at 862-6640