PARALLON
BUSINESS SOLUTIONS℠

PARKRIDGE BEHAVIORAL HEALTH SERVICES
Nashville Health Information Management Service Center (HSC) - Release of Information
552 Metroplex Drive, Nashville Tennessee 37211
Phone: 615.695.8700 Toll Free: 1-866-270-2311 Fax 1-877-865-9738

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Last 4 digit SSN *(optional)*:**	
Provider's Name: **Parkridge Valley Hospital**	**Recipient's Name:**	**Recipient's Phone:**	
Provider's Address: **2200 Morris Hill Rd, Chattanooga, TN 37421**	**Address:**		
Email (If email checked below. Please print legibly):	**City:**	**State:**	**Zip:**

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

This authorization will expire ninety days from the date of signature unless otherwise indicated below.

Date: **Event:**

Purpose of disclosure:

Hospital to Release records from: **PARKRIDGE VALLEY HOSPITAL**

Description of information to be used or disclosed

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 ☐ MD Discharge Summary ☐ DC Instructions/Plan ☐ Physician orders ☐ History & Physical ☐ Medical Consultation ☐ Physician Progress Notes		☐ Intake Assessment ☐ Nursing Assessment ☐ Psychosocial Assessment ☐ Lab/Special Studies ☐ Nursing Notes ☐ Transfer Forms ☐ ER Information		☐ Imaging/Radiology ☐ Cardiac Studies/EKG ☐ Face sheet ☐ Itemized bill: ☐ UB-92: ☐ Dates of Stay Letter ☐ 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)

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.

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:**
ROI updated 04/20/15	

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