Consent to Release Information

Madisonville Clinic	Tellico Plains Clinic	Vonore Clinic
PH: 423-442-2622	PH: 423-253-6545	PH: 423-884-7271
Fax: 423-442-5760	Fax: 423-253-6538	Fax: 423-884-3277
4798 New Hwy. 68	412 Hunt Street	1206 Highway 411
Madisonville, TN 37354	Tellico Plains, TN 37385	Vonore, TN 37885

Patient:	**Date of Birth:**
SS#:	**Phone#:**

☐ **I authorize my records to be sent to Chota Community Health Services, FROM:**

Phone#:	**Fax#:**

☐ **I authorize Chota Community Health Services to send my records TO:**

Phone#:	**Fax#:**

Items Requested

Dates from: _____________to_____________ (last 2 years unless otherwise noted)

☐ **All Records** including, but not limited to: medical notes, mental health notes, behavioral health notes, diagnoses, labs, diagnostic test results, vaccine records, alcohol and drug treatment records, communicable disease records, and billing records for all conditions.

OR

☐ Send only the following records: (CHECK ALL THAT APPLY)

☐ Medical Office Notes ☐ Behavioral Health Office Notes

☐ Labs ☐ Vaccine Record ☐ Radiology Report ☐ Radiology Disc

☐ Drug/Alcohol Records ☐ Psychiatric - Mental Health Notes

☐ Statements/Billing ☐ Communicable Diseases (including AIDS/HIV if applicable)

☐ Other: ____

☐ Any additional restrictions: ____

Delivery Method:

☐ Print

.☐ Fax

☐ Mail

☐ Electronic Delivery

☐ Picked up

☐ Verbal

by:_________________

*** Please allow 7 – 10 days for processing your request. We will fax your records at no charge. However, there may be charge for some purposes – please inquire for details*

Reason for Release: ☐ Transferring Care ☐ Continued Care ☐ Workman's Comp. ☐ Insurance

☐ Disability ☐ Referral ☐ Attorney ☐ Other: ____________________________

I have read, or have had read to me, the above statements and understand them as they apply to me. I further understand that I may revoke this consent at any time with written notification, except to the extent that action has already been taken in accord with the consent. In any event, this consent will **expire 1 year from the date it is signed.** I understand that CCHS will not condition treatment, payment, enrollment, or eligibility for benefits on whether I provide this authorization. I understand that the information used or disclosed may be subject to re-disclosure by the recipient on this request and will no longer be protected by federal regulations. **A copy of this release will be provided to you upon request.**

Signature:	**Relationship:**	**Date:**
Witness:		**Date:**

If you have any questions about this request, you may contact our Chief Compliance Officer at 423-442-2622 3/14/2022