

**TENNESSEE MEDICAL FOUNDATION CONFIDENTIAL AUTHORIZATION
AND CONSENT FORM INFORMATION PRIVACY POLICY**

PRIVACY POLICY: The Tennessee Medical Foundation (“TMF”) protects as confidential and privileged information it generates on physician participants in its Physician’s Health Program (“PHP”). The TMF-PHP is intended to be a “Quality Improvement Committee” as defined in T.C.A. § 63-1-150 and T.C.A. § 68-11-272. Any and all actions of the TMF and the TMF PHP are intended to come within the provisions and protections of T.C.A. § 63-1-150 and T.C.A. § 68-11-272 as contemplated in these statutes. In any event, TMF as a matter of policy does not release copies of any of its records (which are unavailable elsewhere) that are necessarily protected as privileged and confidential under Tennessee and other laws. The TMF will release certain types of information as part of the advocacy process for physician participants. The TMF release forms need to be completed prior to such release. As a general matter, the release of such information is contemplated as part of the advocacy/after care contracts that participants sign. As an additional protection against unauthorized releases (especially by third parties who receive such advocacy information), the PHP requires that the applicable consent and authorization form(s) be completed by each participant *prior to the requested communication or advocacy event*.

RELEASE FORM EXPLANATION: This form has an acknowledgement noting that you have received a copy of this privacy policy. The form authorizes other entities and individuals to release information about you **TO** the TMF-PHP. This is particularly helpful as the PHP follows you, for example, through the assessment and treatment processes. Without this form, the PHP likely will not be able to assist you or advocate for you.

This form also authorizes the TMF-PHP to release information **FROM** its participant file about you as part of the ongoing advocacy process to entities or individuals who need the information to determine whether, for example, your hospital privileges, HMA credentials, or medical license should be kept in place. All requests TMF receives for written information regarding your participation with the program must be submitted to our offices in writing. If you receive a written request for information, it is important that you send us a copy of the request and that the language in the release reflects the information sought. For example, some employers are satisfied with a simple verification that a physician is in the program whereas others require a more detailed account of the physician’s participation. It is critical that we understand the extent of the inquiry so that we know what information to release.

We encourage you to rely upon your personal legal counsel in completing this form. Be sure to submit your request to us one month prior to any deadline and to let us know the deadline. Due to demands on our PHP staff, TMF-PHP policy states that request for advocacy letters or other documentation information will be fulfilled within 10 business days following the TMF-PHP’s receipt of the written request including completion of the applicable consent and authorization form(s). For further information, please contact Michael Todd, TMF Administrator, at (615) 467-6411.



TMF
TENNESSEE MEDICAL
FOUNDATION

PHYSICIAN'S HEALTH PROGRAM (PHP)

5141 Virginia Way, Suite 110
Brentwood, TN 37027
Tel. (615) 467-6411
Fax. (615) 467-6419

**AUTHORIZATION AND CONSENT FOR
RELEASE OF INFORMATION TO & FROM TMF-PHP**

I, _____
(Please print Participants Name)

Home Address: _____
(Street, City, State, Zip)

Office Address: _____
(Street, City, State, Zip)

Home Phone: _____ Office Phone: _____

I ACKNOWLEDGE RECEIPT OF TMF'S PRIVACY POLICY AND HEREBY AUTHORIZE:

The **TENNESSEE MEDICAL FOUNDATION PHYSICIAN'S HEALTH PROGRAM'S STAFF**

and _____
(Please list name and contact information of the **person at this organization** with whom we may correspond.)

Address: _____

Email Address and/or Fax No: _____

Phone Number: _____

TO DISCLOSE/RELEASE TO EACH OTHER:

(Please check all that are appropriate)

- Copy(ies) or summary(ies) of information pertinent to TMF-PHP participation, compliance, aftercare, along with other treatment/assessment facility's information/recommendations.
- Other _____

PURPOSE:

- To facilitate case management and advocacy efforts
- Other _____

I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2, 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Participant's Signature: _____

Date of Signature: _____

EXPIRATION: THIS CONSENT IS SUBJECT TO WRITTEN REVOCATION AT ANY TIME EXCEPT TO THE EXTENT THAT THE TMF PHP WHICH IS TO MAKE THIS DISCLOSURE HAS ALREADY TAKEN ACTION IN RELIANCE ON THIS AUTHORIZATION/CONSENT. THE PARTICIPANT MAY REQUEST A RESTRICTION OF THE USE OF COVERED INFORMATION, BUT, UNLESS IT AGREES, THE TMF-PHP IS NOT REQUIRED TO HONOR THAT REQUEST. IF NOT PREVIOUSLY REVOKED, THIS CONSENT WILL TERMINATE ONE YEAR AFTER SUCCESSFUL COMPLETION OF THE TMF-PHP PARTICIPATION OR AFTERCARE CONTRACT UNLESS ANOTHER DATE IS INDICATED:
_____/_____/_____.