

**Faculty Internal Medicine**  
**Authorization for Release of Information**

**Patient Name:** \_\_\_\_\_  
Last First MI

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Day Phone:** \_\_\_\_\_ **Evening Phone:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ **SS#:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Mo. Day Year

**I hereby authorize: (Only one (1) Provider per release form)**

**Dr/Facility:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**to release information from my medical record as indicated below to:**

**Faculty Internal Medicine**  
**4005 Fountain Valley Drive**  
**Suite 350**  
**Knoxville, TN 37918**  
**Ph. 865-925-9020**  
**Fax 865-377-1042**

**Information to be released:**

<input type="checkbox"/> History and physical exam	Dates: _____
<input type="checkbox"/> Progress notes	_____
<input type="checkbox"/> Lab reports	_____
<input type="checkbox"/> X-ray reports	_____
<input type="checkbox"/> Other _____	_____
_____	_____

**I specifically authorize the release of information relating to:**

Substance abuse (including alcohol/drug abuse)  
 Mental health (including psychotherapy notes)  
 HIV related information (AIDS related testing)

\_\_\_\_\_  
Signature of Patient or Legal Guardian Date

**Purpose of Disclosure:**  Changing physicians  Consultation/second opinion  Continuing care  Legal  
 School  Insurance  Workers Compensation  
 Other (please specify): \_\_\_\_\_

I understand that this authorization will expire on \_\_\_\_\_ (Print the # days until this form Expires, if it does) days after I have signed the form.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

\_\_\_\_\_  
Signature of Patient Date OR Parent/Legal Guardian/Authorized Person Date