

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
11440 Parkside Drive
Suite 302
Knoxville, TN 37934
Ph. 865-544-9740
Fax 865-377-1002

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