FACULTY INTERNAL MEDICINE

# Authorization for Release of Information

Patient Name: _____
Last First MI

Address: _____ City: _____ ST: _____ ZIP: _____

Day Phone: _____ Evening Phone: _____

Date of Birth: _____ - _____ - _____ SSN#: _____ - _____ - _____
Month Day Year

I hereby authorize:

Dr. / Facility / Patient: _____ (Only one Dr. / Facility per form)

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) 218-9220
Fx. (865) 218-3331

**Information to be released:**

☐ All Records

☐ Last 2 years of Office Notes/Labs/Radiology (including cardiac testing); most recent diagnostic procedures (Colonoscopy & Dexa; etc.); all Vaccinations.

☐ Specific: _____

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

☐ Substance abuse (including alcohol/drug abuse) ☐ Mental health (including psychotherapy notes)

☐ HIV related information (AIDS related testing)

X _____ _____
Signature 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 ____ (State 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.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date