Knoxville Family Psychiatry

301 Clark St. Knoxville, TN 37921

Phone: (865) 588-1718 Fax: (865) 338-5897

Patient Name: _____

Birthdate: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization for Release of Medical Information

I authorize Knoxville Family Psychiatry to ☐ **release to** and/or ☐ **obtain** information regarding my treatment to:

Name/Organization/Office: _____ **Phone Number**: _____

Person providing and/or obtaining information: ○ Health Care Provider ○ Family Member ○ Therapist ○ Other

- The purpose of this release is: ☐ at the request of the patient ☐ continuum of care ☐ other
- Information to be **released** and/or **obtained:**
  - ☐ Office Notes
  - ☐ Labs
  - ☐ History & Physical
  - ☐ Abstract
  - ☐ Imaging
  - ☐ Discharge Summary
  - ☐ Medication List
  - ☐ Verbal on-going communication
  - ☐ All the above

Due to the nature of this practice, we will only release notes generated by our practice provider. If you desire copies of notes released to you by other providers, you must obtain those independently.

Unless otherwise revoked, this authorization expires _____ (insert applicable date or event). If no date or event is indicated, this authorization will not expire.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Records Department of Knoxville Family Psychiatry. Such notice will not affect any actions made prior to this authorization. I understand that my healthcare, payment for my healthcare, or insurance status will not be affected if I do not sign this form. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA privacy rules. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this authorization for release of medical information.

_____ **(initials)** I acknowledge, and hereby consent to such, that the released information may contain psychiatric, alcohol and drug abuse, drug testing, HIV testing and results, or AIDS information.

Date _____

Signature of Patient or Parent/Guardian _____

Printed Name _____ **Relationship to Patient** _____