Authorization to Disclose Protected Health Information
The undersigned authorizes to release my health information as noted below

FACULTY INTERNAL MEDICINE

Patient Information:

Patient Full Name: ______________________________ **Other Names:** ______________________

Patient Address: ______________________________ **Date of Birth:** ____/____/___ **Last 4 digits of SS#:** ______

City: ____________________ **State:** _____ **Zip:** __________ **Phone #:** ______________________

Release Information From:

Name/Facility: ________________________________ **Attention:** ________________________

Address: _____________________________________ **Phone:** ___________________________

City: ________________ **State:** ______ **Zip:** ________ **Fax** #: ________________________

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:__________________

Information to be Released:	Information to be released to:
☐ Please release all records ☐ Last **2 years** Office notes/Labs/Radiology (including cardiac testing); most recent diagnostic procedures (Colonoscopy & DEXA, etc); all Vaccinations ☐ **Specific**: ________________________________	☐ **Faculty Internal Medicine** **11440 Parkside Drive, Ste 302** **Knoxville TN 37934** **Ph. (865) 218-9220 Fx. (865) 218-3331** ☐ **Faculty Internal Medicine** **2250 Sutherland Ave, Ste 121** **Knoxville, TN 37919** **Ph. (865) 218-9220 Fx. (865) 218-3330**

Authorization to Release Protected Health Information

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

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:** ____________________________.
4. I understand that information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer be protected by Federal privacy regulations.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

____ ______________________

Signature of Patient **Date**

Legal Guardian/Parent/Authorized Person