Primary Care of Tennessee

11509 Hardin Valley Rd.
Knoxville, TN 37932
Office (865) 200-4101 Fax (865) 200-4039

Diane B. Knights, FNP-BC
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please fill in each section in its entirety. You must have the full address for the facilities listed, please de	o not
submit this form if you are unable to complete it fully.	
Patients Name:	
Social Security Number:	
Date of Birth:	
Physician to PROVIDE records, include name and address:	
Facility to RECEIVE records, include name and address:	
Primary Care of Tennessee	
11509 Hardin Valley Rd.	
Knoxville, TN 37932	
This request and authorization applies to:	
() All healthcare information, including office notes, labs, radiology reports, emergency room	
() Healthcare information relating to the following treatment, condition, or dates of treatment:	
I understand that: I may inspect or copy the protected health information to be used or disclosed. I may receive this authorization in writing by contacting your office at the above address. I understand, unless limited below, this rele also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR part 2) or State Lav 16-39-2) concerning hospitalization or treatment, including but not limited to, information regarding alcohol abuse, substance abuse, communicable disease documentation, human immunodeficiency virus (HIV), or mental health treatment or counseling.	ase w (IC
Attention Privacy Officer: Information used or disclosed pursuant to the authorization may be subject to re-disclosu the recipient and no longer be protected by HIPPA. I may refuse to sign this authorization and that you will not condition treatment or research-related treatment, in which case you may refuse to provide that research-related treatment.	dition