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 do 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:

____

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Facility to RECEIVE records, include name and address:

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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 release also pertains to records whose confidentiality is protected by either Federal Regulations (42 CFR part 2) or State Law (IC 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.

Attention Privacy Officer: Information used or disclosed pursuant to the authorization may be subject to re-disclosure by 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.

Signature____ Date______________