KNOXVILLE Hospital & Clinics
YOUR CORNERSTONE TO HEALTH

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Date of Birth _____ Email _____
Address _____ City _____ State _____ Zip _____ Phone _____

I request that my protected health information (PHI) from _____be disclosed to:
Recipient Name _____ Email _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax (healthcare provider only) _____

I authorize the following PHI to be released from my medical record(s):
__ Abstract/Summary (includes discharge summary, history & physical, operative report(s), consultation(s), & test results
__ Emergency Room Record __ History & Physical __ Discharge Summary
__ Operative Report(s) __ Laboratory Report(s) __ Radiology Report(s)
__ Itemized Billing Statement __ Test Results of _____
__ Radiology Film/Imaging Studies/Tracing/Media
__ Other _____

Covering the period of healthcare from: Specific Date(s) _____ to _____
Purpose for requesting information: __Legal __Insurance __Personal __Continuation of Care __Other

Disclosure format (paper is default if not marked): __Paper format __Fax (healthcare provider only) __Email – secure format
__Flash drive – secure electronic format

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency (AIDS), or human immunodeficiency (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information release/obtained (include dates where appropriate):
Alcohol, Drug, or Substance Abuse Records __Yes __No Dates _____
HIV Testing and Results __Yes __No Dates _____
Mental Health or Psychotherapy Records __Yes __No Dates _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Health Information Management Department at the following address: 1002 S. Lincoln Street, Knoxville, IA 50138.
- Revocation will not apply to information that has already been disclosed in response to this authorization.
- If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment, or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Patient or Authorized Representative Signature Date

If the patient is an unemancipated minor, I certify that I am the patient's legal custodian and that I have full authority to consent to the relapse of protected health information. If the patient is incompetent or deceased, I certify that I am authorized to consent to the release of protected health information.

_____ _____
Print Name Relationship to Patient (if applicable)

For office use only:
Account number _____ Medical record number _____ Processed by _____