KNOXVILLE Hospital & Clinics | An Affiliate of MERCYONE

Authorization to Release Protected Health Information

Medical Records Phone: 641-842-1461
Medical Records Phone: 641-842-7012
Medical Records Fax: 641-335-5302

This form collects information that is part of the medical record. Return to Medical Records to Process

Patient Identification:	**Patient's Name (legal, maiden, other):**		
	Address:	City & State:	Zip Code:
	Date of Birth:	Phone:	
Release Information FROM: (Who is authorized to release the information.)	◯ **Knoxville Hospital & Clinics**		
	Provider Name/Organization:		
	Address:	City & State:	Zip Code:
	Fax:	Phone:	
Send Information TO: (Where authorized information is to be sent.)	◯ **Knoxville Hospital & Clinics |Ph: 641-842-1461 | Fax: 641-335-5302**		
	◯ **The Patient/Patient's Authorized Representative** ◯ **Provider/Organization**		
	Recipient Name (if other than Patient):		
	Address:	City & State:	Zip Code:
	Fax:	Phone:	

Information to be Disclosed:	**Requested Date(s) of Service:**					
	◯ Entire Record	◯ Consult Reports	◯ History & Physical	◯ Lab Results	◯ Immunization Records	◯ Other/Comments:
	◯ Medication List	◯ Discharge Summary	◯ Emergency Records	◯ Radiology Reports	◯ Radiology Images	

***Specific authorization for the release of information protected by state or federal law:** I specifically **do not** authorize the release of information relating to:	Substance Abuse ◯	Mental Health ◯	HIV related Information ◯	**Signature of Patient or Legal Guardian** In order for the information in this section to be **excluded** you must sign here. ✕ ____________________

For the Purpose of: (Check All that Apply)	◯ Transfer Care	◯ Continued Care	◯ Insurance Coverage	◯ Legal	◯ SSA/Disability	◯ Personal Use

Requested Format: ◯ Paper ◯ Fax (only to healthcare provider, insurance, etc.)

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form. The patient or authorized representative may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility cannot condition treatment whether the patient or authorized representative signs the authorization. The patient or authorized representative may be charged for copies of the requested information per state and federal law. It is possible that the information disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by HIPAA. This excludes substance abuse, mental health, and HIV related information.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form.

Authorized Representatives: Please indicate your legal authority below and include documentation of your relationship:
This authorization will expire one year from the date of signing unless the signor indicates an earlier date or event here: ____________.

Signature of Patient or Authorized Representative:		Date:
Printed Name of Authorized Representative (if applicable):		*Provide documentation of relationship*
Authorized Representative's Relationship to Patient (if applicable):		
Signature of Witness:		Date:
If unable to sign document, give reason:		Date: