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**MERCYONE**

# Authorization to Release Protected Health Information

Medical Records Phone: 641-842-1461  
Medical Records Phone: 641-842-7012  
Medical Records Fax: 641-842-7030

This form collects information that is part of the medical record. [Return to Medical Records to Process](#)

<b>Patient Identification:</b>		<b>Patient's Name (legal, maiden, other):</b>					
		Address:		City & State:		Zip Code:	
		Date of Birth:		Phone:			
<b>Release Information</b> <b>FROM:</b> <u>(Who is authorized to release the information.)</u>		<input type="radio"/> <b>Knoxville Hospital &amp; Clinics</b>					
		<b>Provider Name/Organization:</b>					
		Address:		City & State:		Zip Code:	
		Fax:		Phone:			
<b>Send Information</b> <b>TO:</b> <u>(Where authorized information is to be sent.)</u>		<input type="radio"/> <b>Knoxville Hospital &amp; Clinics   Ph: 641-842-1461   Fax: 641-842-7030</b>					
		<input type="radio"/> <b>The Patient/Patient's Authorized Representative</b>					
		<input type="radio"/> <b>Provider/Organization</b>					
		<b>Recipient Name (if other than Patient):</b>					
		Address:		City & State:		Zip Code:	
		Fax:		Phone:			
<b>Information to be Disclosed:</b>		<b>Requested Date(s) of Service:</b>					
		<input type="radio"/> Entire Record	<input type="radio"/> Consult Reports	<input type="radio"/> History & Physical	<input type="radio"/> Lab Results	<input type="radio"/> Immunization Records	<input type="radio"/> Other/Comments:
		<input type="radio"/> Medication List	<input type="radio"/> Discharge Summary	<input type="radio"/> Emergency Records	<input type="radio"/> Radiology Reports	<input type="radio"/> Radiology Images	
<b>*Specific authorization for the release of information protected by state or federal law:</b> <u>If marked, I specifically do not authorize the release of information relating to:</u>		Substance Abuse	Mental Health	HIV related Information	<b>Signature of Patient or Legal Guardian</b> In order for the information in this section to be <b>excluded</b> you must sign here.  <input checked="" type="checkbox"/>		
<b>For the Purpose of:</b> (Check All that Apply)		<input type="radio"/> Transfer Care	<input type="radio"/> Continued Care	<input type="radio"/> Insurance Coverage	<input type="radio"/> Legal	<input type="radio"/> SSA/Disability	<input type="radio"/> Personal Use
<b>Requested Format:</b>		<input type="radio"/> Paper		<input type="radio"/> Fax (only to healthcare provider, insurance, etc.)			
<p><b>ATTENTION:</b> 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.</p> <ul style="list-style-type: none"> <li>• If the patient is 18 years of age or older, the patient must sign and date the form.</li> <li>• 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.</li> </ul> <p>Authorized Representatives: <u>Please indicate your legal authority below and include documentation of your relationship:</u> This authorization will expire one year from the date of signing unless the signor indicates an earlier date or event here: _____.</p>							
<b>Signature of Patient or Authorized Representative:</b>						Date:	
<b>Printed Name of Authorized Representative (if applicable):</b>						<i>*Provide documentation of relationship*</i>	
<b>Authorized Representative's Relationship to Patient (if applicable):</b>							
<b>Signature of Witness:</b>						Date:	
<b>If unable to sign document, give reason:</b>						Date:	