

University of Tennessee Medical Center
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Knoxville, TN 37920

Telephone: (865) 544-6970
Fax: (865) 544-6114

**INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION.**

I hereby authorize _____
to release, use or disclose information from the health record of:

Patient Name: _____ Date of Birth _____

Address: _____ Telephone No: _____

_____ Soc Sec No: _____

Covering the period(s) of health care from _____ to _____
the following:

- | | |
|--|---|
| <input type="checkbox"/> Complete Medical Record(s) | <input type="checkbox"/> Pathology |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Laboratory Test |
| <input type="checkbox"/> History & Physical Exam | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Orders and Progress Notes | <input type="checkbox"/> Operative Report |
| <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Inspect Records |
| <input type="checkbox"/> Other (Specify) _____ | |

The information will be used or disclosed for the following purpose(s):

- To assist in the provision of services, care, and treatment of the individual.
- At the request of the individual.
- Other: _____

To: _____

Address: _____

Fax: _____

You have a right to revoke this authorization by doing so in writing and mailing to the above address above.

Such revocation will be effective to the extent that action has not been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy.

The information used or disclosed under the authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.

I understand I may inspect and/or copy the signed disclosure of Protected Health Information form.

Date: _____

Signature

**This authorization expires 1 year
from date of signature.**

Print Name

Authority of Personal Representative If Signing for the Individual