The University of Tennessee Medical Center
1520 Cherokee Trail, Suite 105
Knoxville, TN 37920
865-305-6970

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:

- ☐ **Complete Medical Record(s)**
- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Orders and Progress Notes
- ☐ X-Ray Reports
- ☐ Pathology
- ☐ Laboratory Test
- ☐ Consultation Reports
- ☐ Operative Report
- ☐ Inspect Records
- ☐ 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:__________________

This authorization expires 1 year from date of signature.

____
Signature

____
Print Name

____
Authority of Personal Representative If Signing for the Individual