Authorization for Release of Protected Health Information

Patient Name: _____ MRN #: _____

Address: _____ Date of Birth: _____

_____ SS #: _____

I authorize my protected health information to be:

Released to: _____

Address/Phone/Fax: _____

Obtained From: _____

Address/Phone/Fax: _____

Please specify information to be released/obtained: Purpose of release:

____ Complete Record	____ OP Notes	____ Continuing medical care
____ Last Visit	____ H&P	____ Released to patient
____ OB Records	____ HIV/STD test(s)	____ Insurance purposes
____ Labs	____ Pap/Biopsy	
____ Mammogram	____ Consult	

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and /or HIV status. I understand and agree that the information , if and, pertaining to any such diagnosis/treatment described above my be released. I understand that my medical record may contain information from other health care providers, which has been filed with my medical record. I understand this release is valid for ninety (90) days from the date of your signature below.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Women's Care Group Knoxville

1930 Alcoa Highway, Building A, Suite #240 • Knoxville, Tennessee 37920 • 9220 Dutchtown Road, Knoxville, Tennessee 37923

865-238-1040 • Fax: 865-305-6712 • **utmedicalcenter.org**