REQUEST FOR MEDICAL RECORDS

UNIVERSITY SURGICAL ONCOLOGY
1926 ALCOA HWY, Bld F SUITE 330
KNOXVILLE, TN. 37920-6999
PHONE: (865) 544-9218 FAX: (865) 305-8262

TO:____

ADDRESS:____

____

PHONE: (______)______________________ **FAX**: (______)__________________________

Please send any and all medical records including the diagnosis, treatment and/or examination rendered to the below named patient, during the time period of:

________________ **to** _________________

I authorized the release of these records by mail or facsimile to University Surgical Oncology. Effective for 90 days from ___________________

Patient Name: (print)____

____

Date of Birth:____

Signature of Patient:____

****In the event that I am referred to another specialist of facility for continuity of care, I give University Surgical Oncoloy permission to forward all of my medical records, including those sent by my referring physician.**

____________________________________ ______________________________
Patient Signature **Date**

University Surgical Oncolongy
1926 Alcoa Highway, Bldg. F, Suite 330
Knoxville, Tn 37920
Phone (865) 544-9218 / Fax (865) 305-8262

Patient Privacy Questionnaire

Please print
Patient's Name: ____

1. May we leave confidential messages regarding appointments, return calls, etc. with anyone who answers the telephone at your home? YES NO

2. May we leave confidential messages regarding appointments, return call, etc. with your home answering machine or voicemail? YES NO

3. Is there a number other than your home number where we can leave a confidential message with anyone answering the telephone regarding appointments, lab results or other healthcare information? (please list below) YES NO

List anyone that may call and get personal health information on your behalf.

Name	Phone #	Relationship
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________
___________________	___________________	___________________

4. If we are unable to reach you by any of the above options, may we leave messages regarding appointments, return calls, etc. at your place of employment?
YES NO N/A

5. May we send information through the U. S. Postal Service to your home address? YES NO

I have been notified that I can obtain a copy of the University Health Systems (UHS) Notice of Information Practices by calling (865) 305-9118 or on the web at www. Utmck.edu, or by requesting one at UHS or UHSV office. I understand that this Notice describes how my health information maybe used or disclosed by UHS, UHSV facilities and that I should read it carefully. I am aware that the Notice may be changed at any time.

_____________________________________ _______________

Signature of Patient or Guardian **Date**

DATE ______________

PATIENT REGISTRATION

FOR INTERNAL USE ONLY
PATIENT NUMBER ____________

PATIENT INFORMATION

SOCIAL SECURITY # ______________________

FIRST NAME ______________ MIDDLE ______

LAST NAME ______________________

SEX ______ DATE OF BIRTH ______________

MARITAL STATUS ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

(CHECK ONE)
☐ EMPLOYED ☐ RETIRED
☐ FULL TIME STUDENT ☐ OTHER

EMPLOYER ______________________

HOME ADDRESS ______________________

____

CITY ______________ STATE ____ ZIP ______

EMAIL ______________________

HOME PHONE (_____) ______________

WORK PHONE (_____) ______________

CELL # (_____) ______________

REFERRING PHYSICIAN ______________________

HOW DID YOU HEAR OF US? ______________________

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURED / CARD HOLDER'S NAME ______________________

RELATIONSHIP ______________ DOB __________ SOC. SEC. # __________

SECONDARY INSURANCE INFORMATION

INSURED / CARD HOLDER'S NAME ______________________

RELATIONSHIP ______________ DOB __________ SOC. SEC. # __________

EMERGENCY CONTACT

RELATIONSHIP ______________________

FIRST NAME ______________ MIDDLE ______

LAST NAME ______________________

SEX ________

HOME PHONE (_____) ______________

WORK PHONE (_____) ______________

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY # ______________________

RELATIONSHIP ______________________

FIRST NAME ______________ MIDDLE ______

LAST NAME ______________________

ADDRESS ______________________

CITY ______________ STATE ____ ZIP ______

SEX ______ DATE OF BIRTH ______________

DAYTIME PHONE (_____) ______________

EMPLOYER ______________________

ADDRESS ______________________

CITY ______________ STATE ____ ZIP ______

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIAN: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

______________________________ ______________
SIGNATURE (Patient or Parent if Minor) DATE