UT Medical Center and Baptist West (Knoxville)
Authorization for Release of Protected Health Information

Patient Name:___________________________________ Chart Number:________________________

Address: ___________________________________ Date of Birth: ________________________

___________________________________ SS Number: ________________________

Patient Insurance:________________________________ Phone Number: ______________________

Purpose of release:

☐ Continuing medical Care

☐ Release to patient

☐ Insurance coverage

☐ Insurance reimbursement

I authorize my protected health information to be:

☐ Release to: ____

Address/Phone/ Fax___________________________________

☐ Obtained from: ______________________________________

Address/Phone/Fax____________________________________

Please specify information to be released/obtained:

☐ Complete Record	☐ Op Notes
☐ Last Visit	☐ H&P
☐ OB Records	☐ HIV/STD Test(s)
☐ Labs	☐ Pap/Biopsy
☐ Mammogram	☐ Consult

Statement of Time Limitations

I understand that this authorization is valid for ninety (90) days from the date of signature below. If a long/shorter period of time is desired please specify the desired time frame in the spaces below:

_____________________ To___________________

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 any, pertaining to any such diagnosis/treatment described above may be released. I understand that my medical record may contain information from other health care providers, which has been filed with my medical records.

____ _______________________________

Patient Signature *Date*

____ _______________________________

Witness Signature *Date*

Upon completion fax this form to: Knoxville Medical Records Office @ 865-525-1116

If you have any questions of need assistance call Knoxville Medical records @ 865-540-4483