



LISTENING TO YOU. CARING FOR YOU. CLOSE TO YOU.

Maryville Office
Authorization for Release of Protected Health Information

Patient Name: Chart Number:
Address: Date of Birth:
SS Number:
Patient Insurance: Phone Number:

Please fill out completely to insure accurate and prompt receipt of records

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
Last Visit
OB Records
Labs
Mammogram
Op Notes
H&P
HIV/STD Test(s)
Pap/Biopsy
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: Maryville Medical Records Office @ 865-681-7949
If you have any questions of need assistance call Maryville Medical records @ 865-984-9017