Knox County Health Department
Authorization to Use or Disclose Health Information

Patients Name ______________________________

Medical Record Number______________________________

Social Security Number______________________________

Date of Birth______________________________

I hereby authorize Knox County Health Department to **request** / **release** (circle one) Protected Health Information. This information can be used by or disclosed to the following organization:

TO / FROM	**TO / FROM**
☐ Knox County Health Department Department: Medical Records 140 Dameron Avenue Knoxville, TN 37917 Phone: 865-215-5024 Fax: 865-215-5002	☐ Name: ______________________ Address: ______________________ ______________________ Phone: ______________________ Fax: ______________________

The type of information to be used or disclosed is as follows (check the boxes you want released / requested include other information where indicated):

☐ All services occurring in the last 3 years	☐ Most recent History
☐ Entire Record	☐ Most Recent Discharge Summary
☒ Immunization Records	☐ Prenatal Records
☐ List of Allergies	☐ Current Medication List
☐ Lab Results (dates or types of lab test you would like disclosed): ______________________ ______________________	☐ Consultation Reports form (please supply doctor's name): ______________________ ______________________
☐ X-ray and Imaging Reports (dates or types of x-rays or images you would like disclosed): ______________________	☐ Other (please describe)______________________ ______________________

I understand that the information in my health record may include information relating to (check only boxes you want released / requested):

☐ Sexually Transmitted Diseases	☐ Family Planning
☐ Acquired Immunodeficiency Syndrome (AIDS)	☐ Behavioral/Mental Health Services (not including Cherokee Mental Health Records)
☐ Human Immunodeficiency Virus (HIV)	☐ Treatment for Alcohol and Drug Abuse

The information for which I am authorizing disclosure will be used for the following purpose:

- ☐ My Personal Records
- ☒ Sharing with Other Health Care Providers as needed
- ☐ Other (please describe): ______________________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations unless there are specific federal or state laws or regulations which prohibit disclosure. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand that Knox County Health Department may receive compensation for its use/disclosure of the information released following this authorization.

This authorization will expire 12 months from the date on which it was signed unless specified otherwise. _________________(Date of Expiration)

__X__ I have received a copy of this authorization.

_____ Since the patient is unable to read, I have explained the material verbally and answered his/her questions. (Please initial)

X______________________________ ______________________

Signature of Patient / Legal Representative (relationship) Date

______________________________ ______________________

Signature of Witness Date