

HEALTH INFORMATION AUTHORIZATION

Return To Knox County Human Resources
Fax: 865.215.2474
400 Main Street
Suite 360, City County Building

Please complete the following form to specify the use or disclosure of health information that you are authorizing. Federal rules providing certain protections of the privacy of individuals' health information may require your authorization before the Plan may use, receive or disclose health information.

Employee Last Name: _____ First: _____ MI: ____
Employee FAX #: _____ Phone #: _____
Social Security #: _____ Department: _____
Patient Name that authorization pertains to: _____

Authorization to Use or Disclose Health Information

1. Specific description of the health information that I am authorizing to be used, disclosed or released (including dates to which the information pertains, if applicable):

Describe claims or issue in question:

Important Information About This Authorization and Your Rights:

- a) You may refuse to sign this Authorization. The Plan will not condition eligibility for, enrollment in, or payment of benefits under the Plan on provision of this Authorization.
- b) You may revoke this Authorization at any time by providing a written and signed statement.
- c) You may inspect or copy the health information described in Item 1 by requesting to do so.
- d) If health information is disclosed pursuant to this Authorization it may no longer be protected under the terms of the federal rules providing certain protections of the privacy of individuals' health information, and that health information may be redisclosed by the recipient.

I hereby certify that I have read the provisions of this Authorization, and that I understand and agree to its terms. The use, disclosure or release of information is at my own request.

Signature of Individual
(Guardian in the case of a minor child)

Authorization Expiration Date

Date of Signature

Revocation of Authorization