THE UNIVERSITY OF TENNESSEE KNOXVILLE
STUDENT HEALTH CENTER

UT Student Health Center
1800 Volunteer Boulevard
Knoxville, TN 37996
Phone: (865) 974-8248 Fax: (865) 974-2632
medicalrecords@utk.edu

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORDS

(Please Print)

Patient Last Name _____ First Name _____ MI _____ DOB _____ Social Security # _____

Date(s) of Treatment_____

Patient Phone #:_____

I **hereby authorize and request copies of my mental health records to be released from:**

Provider's Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

To be released to:

Name: University of Tennessee Student Health Center Psychiatry Clinic
Address: 1800 Volunteer Blvd. Knoxville, TN 37996
Phone: (865) 974-8248 Fax: (865) 974-2632

CHECK INFORMATION REQUESTED

____Psychiatrist or PCP Office Visit/Treatment Notes ____Diagnostic Test Results
____Other (specify):

REASON FOR REQUEST

____Continuity of Care (follow-up) ____Consultation ____Insurance
____School Transfer ____Personal ____At the request of individual

Init_____ This consent ( ) includes ( ) does not include release of any information pertaining to a condition related to a sexually transmitted disease including Human Immunodeficiency Virus (HIV). I understand that such information may not be released without my specific consent except in accordance with a court order.

Init_____ This consent does not apply to any counseling records.

Init_____ I agree that verification of clinic visit may be given for school or work purposes.

Init_____ I understand that this information, once disclosed, may be re-disclosed outside the privacy rule.

Init_____ I understand that I have the right to refuse to sign this form, and my refusal will not result in the ability or inability to condition treatment, payment, enrollment, or eligibility for benefits.

Init_____ The authorization of release pertains only to the above specified information and to the above specified parties. I understand that I may revoke this authorization at any time in writing and the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

_____ _____ _____
Signature of Patient/Legal Representative Relationship to Patient Date

_____ _____
Witness (SHC Staff Member) Date