



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

(Please Print)

Last Name First Name MI DOB Social Security #

Date(s) of Treatment: _____ Which years were you enrolled at the University: _____

Patient Phone #: _____

I hereby authorize and request copies of my medical records from:

Name: _____ University of Tennessee Student Health Center _____ Provider _____
Address: _____ 1800 Volunteer Blvd. Knoxville, TN 37996 _____
Phone: _____ (865) 974-5080 _____ Fax: _____ (865) 974-2632 _____

To be released to:

Name: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____

***ONLY IMMUNIZATIONS CAN BE FAXED – ALL OTHER MEDICAL RECORDS MUST BE MAILED OR PICKED UP**

CHECK INFORMATION REQUESTED

____ Office Notes ____ Lab Tests ____ X-Ray Report ____ Immunizations
____ Pap Smear Report ____ GYN Physical Exam ____ Biopsy Report ____ Consultation Report
____ Accounting of PHI Disclosure ____ Complete Medical Record ____ Other (specify) _____

REASON FOR REQUEST

____ Continuity of Care (follow-up) ____ Consultation ____ Insurance
____ School Transfer ____ Personal ____ At the request of individual
Information to be: ____ Mailed ____ Picked Up ____ Faxed (Immunizations only)

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/mental health records. These records may be obtained with a records release specific to that treatment area.

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

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.

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.

Signature of patient/legal representative

Relationship to patient

Date

Witness (SHC Staff Member)

Date