THE UNIVERSITY OF TENNESSEE KNOXVILLE
STUDENT HEALTH CENTER

UT Student Health Center
1800 Volunteer Boulevard
Knoxville, TN 37996
Phone: (865) 974-5080 Fax: (865) 974-2632

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: _____
Address: _____
Phone: _____ Fax:_____

To be released to:

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

***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

Revised: 8/7/2024