KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Authorization for Release of Information (TO)

Patient Name (include previous name):_____

Date of Birth:_____ Phone:_____

Address: _____Apt#: _____

City/State/Zip:_____

IMPORTANT: Charges for this request may apply. Allow 30 business days for processing. Form must be HIPPA compliant and will not be processed if invalid.

I hearby grant my permission for the release or review of the following information concerning my health care.
Physician/Site authorized to **Release** Information **TO**:
Name:_____
Address:_____
_____
Phone:_____ Fax:_____

INFORMATION TO BE RELEASED (Check all that apply):

☐MEDICAL RECORDS ☐DENTAL RECORDS ☐BEHAVIORAL HEALTH RECORDS

☐LAB REPORTS ☐DIAGNOSTIC IMAGING
☐IMMUNIZATION RECORDS ☐OTHER (SPECIFY)_____

List other facilities records to be included when releasing for the purpose of continuing medical care:
_____
_____

I understand that this authorization shall be valid for (1) year unless revoked through written notice to the Knox County Community Health Center.

I AUTHORIZE RELEASE OF MY MEDICAL RECORDS IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I UNDERSTAND WRITTEN NOTICE IS NECESSARY TO CANCEL THIS REQUEST.

SIGNATURE OF PATIENT_____ DATE_____

If signed by a legal representative, please provide your relation to the patient (i.e. guardian, power of attorney, executor) and **any required documentation to support this relationship.**