Allergy Specialists
OF KNOXVILLE, PLLC
www.AllergySpecialistsofKnoxville.com
1346 Dowell Springs Blvd, Knoxville, TN 37909
Phone: 865-588-2753 Fax: 865-588-7418

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

Patient Name: _____Date of Birth: _____

I hereby authorize _____and its physicians, employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

I hereby authorize the release of medical records to: Allergy Specialists of Knoxville
Name

1346 Dowell Springs Blvd., Knoxville, TN 37909 Fax 865-588-7418
Address and/ or Fax Number

This medical information may be used by the person(s) I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records (past, present and future)

_____ Health care information relating to the following treatment, condition, or dates of treatment: From: _____To:_____

_____ Specific records to be released (e.g. Labs, imaging reports, other):

_____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.
_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except that revocation is not effective to the extent the practice has relied on the use or disclosure of the health information. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition my treatment on the signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____ Relationship to Patient