TRINITY
MEDICAL ASSOCIATES

Authorization for disclosure of medical information

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone # (____)_____

_____

Guardian (If patient is under 18 years of age or mentally incompetent) _____

I hereby authorize the use, disclosure and/or release of my health information (medical records) as described below.

Period Covered: From (date) _____ to (date) _____

Information to be disclosed (Check all that apply):
____ Complete Health Record
OR Only the following information:

____ History and Physical Examinations
____ Progress Notes
____ X-Ray Reports
____ Billing Records
____ Consultation Reports
____ Laboratory Reports
____ Photographs/Images
____ Dietician Records

Special Consent Required:
_____ (Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, Mental Health, Psychiatric Care, Alcohol/Drug Abuse Records. This information will not be released unless specifically stated by initialing above.

The information is to be disclosed to:
Trinity Medical Associates
280 Fort Sanders West Blvd., Suite 101
Knoxville, Tennessee 37922
(865) 539-0270 FAX (865) 539-6998

The information disclosed by:
_____
_____
_____
_____

For the purpose of: _____, ____or at the request of the patient.

I understand that I may revoke this authorization by submitting a request in writing to: Administrator C/O Trinity Medical Associates, PC 280 Fort Sanders West Blvd #101, Knoxville, TN 37922. Furthermore, I understand that Trinity Medical Associates, PC will not be responsible for any charges that may be assessed by the disclosing entity for copying medical records. I understand that I may also refuse to sign this request if I do not wish to have my medical information released.

Signed: _____ _____
Patient Date

_____ _____
Witness Date

This request expires on: _____
Date