Greater Knoxville Dermatology, PLLC

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AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Physician to provide records: _____
Physician to receive records: _____
Patient's name: _____
Social Security #: _____ DOB: _____
Address:_____
_____

Release these records: **Initials**

1. Only records generated by this facility (not including records from other sources) ☐____
2. Only some portion of records maintained at facility (specify below) ☐____
3. All medical records at this facility ☐____

If you do not want certain portions of your medical records released, please read this section carefully and initial the boxes for information you do not want released. Otherwise, your records will be released as specified above.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials **Initials**

☐____ Substance abuse, if any ☐____ AIDS/HIV, if any
☐____ Psychological or psychiatric conditions, if any

Other (please specify) _____

Expiration or revocation of authorization:
I understand that I may revoke this authorization at any time, and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.
Use of copies: A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name (print) Person authorized to sign for patient:

_____ _____

_____ _____
Patient's signature Signature/relationship to patient

Date: _____ Date: _____

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