Knoxville Gastrointestinal Specialists

Fort Sanders Office
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Knoxville, TN 37916

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The purpose of this form is to obtain authorization for use or disclosure of the protected health information.

Patient authorization for Use/Disclosure of Health Care Information

Patients Name: _____ Acct #: _____

Date of Birth: _____ SSN: _____

I request and authorize **Knoxville Gastrointestinal Specialists** to release health care information of the patient named above to:

Name: _____

Address: _____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

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

_____ All health care information

This authorization expires on: _____
(Date)

Or when the following event occurs: _____

I may revoke this authorization to the extent allowed by law. If I do, I understand that healthcare information may have already been released about me at the time that I gave permission in reliance to my original authorization.

I may revoke this authorization by writing a letter to Knoxville Gastrointestinal Specialists. If I write a letter to Knoxville Gastrointestinal Specialists, it must say that I want to revoke my authorization to disclose the patients' health care information. My letter must include the name or the other specific identification of the person (s) that I no longer want to receive information. I (or my authorized representative for health care) must sign and date the letter.

Once Knoxville Gastrointestinal Specialists gives out the information that I want released, I know that Knoxville Gastrointestinal Specialists has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

This disclosure will not result in payment to Knoxville Gastrointestinal Specialists.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Patients Signature: _____ Date: _____