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 Direct of Maryville
1515 E. Lamar Alexander Parkway
Maryville, Tennessee 37804
Phone:(865) 980-8551 FAX:(865) 444-6008

The information disclosed by:
____
____
____
____

Are you leaving the practice? Yes No. If so, please let us know the reason.______________________
____

I understand that I may revoke this authorization by submitting a request in writing to: Administrator C/O Trinity Medical Associates, PC 10437 Hardin Valley Road Knoxville, TN 37931. Furthermore, I understand that once Trinity Medical Associates, PC releases my information in accordance with this request; they no longer maintain control over that information. 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: ____________________