

# TRINITY

## DIRECT PRIMARY CARE

Healthcare without hassles, built for you.

### 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

\_\_\_ Consultation Reports

\_\_\_ Progress Notes

\_\_\_ Laboratory Reports

\_\_\_ X-Ray Reports

\_\_\_ Photographs/Images

\_\_\_ Billing Records

\_\_\_ 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 of Hardin Valley**  
**10437 Hardin Valley Road**  
**Knoxville, Tennessee 37931**  
**Phone:(865) 244-1800 FAX:(865) 444-6002**

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 Direct Primary Care, PLLC 10437 Hardin Valley Road Knoxville, TN 37931. Furthermore, I understand that once Trinity Direct Primary Care, PLLC 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: \_\_\_\_\_