11217 West Point Drive Suite 2 Knoxville, TN 37934 (865) 675-4342

Medical Information Release Form
(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number: _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day)_____ between (time)_____

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____

*If we are unable to reach you by any other means, we will send information through the U.S. Postal Service to your home address.

*I give Family Health Center, PLLC my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies for health care operations.

*I understand that Family Health Center, PLLC has the right to change their privacy practices and that I may obtain any revised notice at Family Health Center, PLLC.