KNOXVILLE INSTITUTE OF DERMATOLOGY

Authorization for Release of Medical Records

I hereby authorize the use and disclosure of my health information as described below. I understand the information disclosed in accordance to this form may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient name: _____ **DOB**: _____

Address: _____

Phone: _____

☐ PROVIDING ☐ RECEIVING ☐ PROVIDING ☐ RECEIVING

Knoxville Institute of Dermatology, PLLC
6516 Kingston Pike
Knoxville, TN. 37919
Phone: (865) 450-9361
Fax: (865) 450-9362

Name: _____

Phone: _____

Fax: _____

Description of records requested, including dates (H&P, progress notes, labs, x-rays, etc.):

_____

*I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. If the authorization for the disclosure of information is necessary for research, which includes treatment, refusal to sign this form may result in the physician declining to provide the research-related treatment, and 2. If the authorization for the disclosure of information is for the sole purpose of disclosure to a third party, refusal to sign this form may result in the doctor declining to provide the healthcare that is for the sole purpose of creating protected health information for this third party.

*I understand that this form expires 1 year after the date signed.

*I understand that I may revoke or change this authorization at any time by notifying the healthcare provider in writing. The changes will only be effective from the date it is received in this office, and it will not apply retroactively.

*I understand that I may request a copy of this statement should I so desire.

*I understand that the healthcare provider requesting information will not receive financial compensation in exchange for using or disclosing health information as specified above.

Patient Signature: _____ **Date**: _____

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