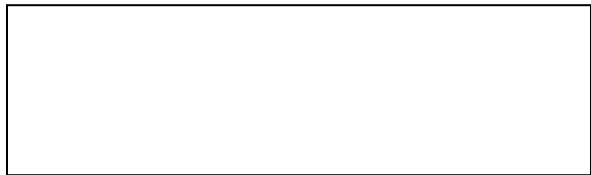
KNOX COUNTY
HEALTH DEPARTMENT



AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

PLEASE SELECT ONE

☐ I hereby authorize Knox County Health Department (____________________Dept.) to **get** my protected health information **from**:

Name: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

☐ I hereby authorize Knox County Health Department (____________________ Dept.) to **provide** my protect health information **to**:

Name: ____________________

Address: ____________________

Phone: ____________________ Fax: ____________________

FOR KNOX COUNTY HEALTH DEPARTMENT OFFICE USE ONLY.

The protected health information will be faxed to: ____________________. Call 865-215-__________with any questions.

PLEASE COMPLETE BOTH SECTIONS 1 AND 2

1. The boxes I checked below and in Section 2 indicate the information I allow KCHD to get or provide, including any other information indicated:

☐ Entire record

☐ All services provided by Knox County Health Department ☐ Most recent history ☐ Most recent discharge summary

☐ All services occurring in last three years ☐ Prenatal records ☐ Most current medication list

☐ Immunization record ☐ List of allergies

☐ Lab results (Dates and types of lab results): ____________________

☐ Consultation reports (Dr. name[s]): ____________________

☐ X-ray/imaging reports (Dates and types of x-rays/images): ____________________

☐ Other: ____________________

2. I understand that my health record may include information related to the topics listed below. KCHD will NOT get or provide any information related to these topics unless I permit it, therefore I have checked all the applicable boxes below for the information I want KCHD to get or provide.

☐ Not applicable ☐ Sexually transmitted infection(s) ☐ Family planning

☐ Acquired immunodeficiency syndrome (AIDS) ☐ Treatment for alcohol and drug misuse

☐ Human immunodeficiency virus (HIV) ☐ Behavioral/mental health services (Not including Cherokee Mental Health records)

The information for which I am authorizing Knox County Health Department to get or provide will be used for the following purpose(s):

☐ Personal records (for me) ☐ Sharing with other health care provider(s) ☐ Other: _________________________________

I understand that I have the right to request restrictions as to how my health information may be used or disclosed. If the restrictions are accepted by KCHD, they are binding. I do understand that KCHD is not required to agree with the restrictions requested. I can revoke the request for restrictions in writing only, except to the extent KCHD has already taken action based on my requested restrictions. All restrictions are approved for one year. Please check one.

☐ I request the following restrictions to the use or disclosure of my protected health information**:**

☐ Please send my protected health information to the following alternate address:

☐ I have no restrictions.

This authorization will expire 12 months from the date on which it was signed unless otherwise indicated. ______________ (Date of expiration). I understand that I have the right to cancel this authorization at any time. If I do, I must do so in writing and present my written cancellation to the medical records manager. I understand that the cancellation will not apply to the information that has already been released in response to this authorization.

I understand that once the above information is disclosed, it may be disclosed by the recipient and the information may not be protected by federal privacy laws/regulations unless there are specific federal/state laws or regulations that prohibit disclosure. I understand authorizing the use/disclosure of the information identified is voluntary. I need not sign this form to ensure health care treatment. I understand that KCHD may receive compensation for its use/disclosure of the information released following this authorization.

☐ Patient was unable to read. I explained the material verbally and answered his/her questions. ______ (Staff initials)

____	____	____________________
Signature of Patient/Legal Representative	Relationship to Patient (If applicable)	Date
____	____	____________________
Signature of Witness (**KCHD staff)**	Title	Date