**140 Dameron Avenue, Knoxville, TN 37917**
**Phone: 215-5000 Fax: 215-5002 TDD: 215-5001**

# PATIENT'S PERMISSION AND PRIVACY AGREEMENT

## Section 1 Permission for Service

I, the signer, am the patient, or the patient's legal representative. I voluntarily agree to and give permission for medical care and treatment by Knox County Health Department (KCHD), its physicians, employees, and/or agents. This care and treatment include all diagnostic and therapeutic treatments, including vaccinations, considered needed or appropriate in the judgment of the physician and provided by KCHD. Any health information from the care and treatment provided by KCHD, its physicians, employees, and/or agents may be used or shared for treatment, payment, or operations purposes.

If needed for medical referrals, KCHD will share information about sexually transmitted diseases (STDs), acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), family planning, or treatment for substance abuse or mental health services. By signing this form, I allow KCHD to share this information to improve and coordinate my care. If I ask, KCHD may give me a copy of test or diagnostic results, office notes, immunization records or any information from today's visit.

I am aware that the practice of medicine is not an exact science and I agree that no guarantees have been made to me as to the result of treatments or examinations performed by the physician or KCHD.

To protect against the spread of bloodborne diseases, such as hepatitis B and C, and HIV, I understand that it may be needed to test my blood for certain diseases if there is an accidental exposure to another patient or employee at KCHD. I understand and agree that my blood, as well as the blood of any person accidentally exposed to my blood, will be tested. I understand that my blood will not be tested for these diseases unless ordered by KCHD and that the results of all tests will be kept confidential. If such testing is needed, it will be performed at no charge to the patient.

## Section 2 Permission for KCHD to Speak with Others

If you are unavailable, KCHD may contact other trusted person(s) about your health care. Please list those individuals below. **If you no longer want us to speak to the person(s) you listed below, please let us know by asking to complete another form. Sexually transmitted disease (STD) test results will be given only to the patient.**

**______ (Initials of patient/representative) You do not want KCHD speaking with others if you are not available.**

| Name /Phone Number | Relationship | ONLY Options |
|---|---|---|
| | | □ Appointment Information<br>□ Lab Results |
| | | □ Appointment Information<br>□ Lab Results |
| | | □ Appointment Information<br>□ Lab Results |

## Section 3 Privacy Agreement

I have reviewed and accepted the information in KCHD's **Notice of Privacy Practices (NPP)**. The NPP provides a complete description of how my health information is used and shared. I understand that the NPP is also posted at each clinical location where services are provided, on the internet at www.knoxcounty.org/health, and I can ask for a paper copy. I also understand that I have the right to review the NPP before signing this agreement.

Label:
Name
DOB

## Section 4 Right to Ask for Restrictions

I have the right to ask for restrictions as to how my health information may be used or shared, released to carry out treatment, payment, or health care operations by KCHD. I do understand that KCHD is not required to agree with these restrictions. I can remove the request for future restrictions in writing only. All restrictions are approved for one year. I may ask that my electronic health information be reviewed and discussed with me before the release of that information to my portal.

**Please INITIAL (This section is not for authorization to release medical information.)**

**NO RESTRICTIONS**

_________ (Patient's/representative's initials) I have no treatment, payment, or health care operation restrictions.

**- - - - - - - - - - OR - - - - - - - - - -**

**RESTRICTIONS**

________ (Patient's/representative's initials) I ask for the following restrictions of the use or sharing of my protected health information to carry out treatment, payment, or health care operations: □ Self-Pay □Other: ________________________

________ (Patient's/representative's initials) Please send my protected health information to this address instead of my main address on file: ______________________________________________________________________________

## Section 5 Signatures

I have read all **FOUR** sections of this form, or had it read to me, and I fully understand and accept its contents unless noted.

| Patient (person being seen today) | Parent/Guardian/Representative of Patient |
|---|---|
| ______________________________________________ **Patient's Signature** | ______________________________________________ **Parent/Guardian/Representative Signature** |
| ______________________________________________ **Patient's Name (Printed)** | ______________________________________________ **Parent/Guardian/Representative Name (Printed)** |
| ____________________ **Date** | _________________ **Date** ____________________ **Relationship to Patient** |

**Vaccinations for Minors:**
Under penalty of misrepresentation, I confirm that I am the parent/legal guardian of, (print minor patient's name) ______________________________ and have parental authority to provide written consent for vaccination as required by Tennessee Code §63-1 by **signing here**________________________________________________________________

**(If applies, complete this section) Incapacitated:**

Patient, ______________________________, is unable to sign because_______________________________________

**(Optional) Other Parent/Guardian/Representative that can seek consent to care for this minor:**

__________________________________________________ ________________________________________

Print Name of OTHER Parent/Guardian/Representative Relationship to Patient

**KCHD Staff:**

_______________________________________ _________________

Signature of Witness Date

**For KCHD Office Use Only:** Patient refused to sign this form after effort to obtain acknowledgement. Describe why patient would not sign: ______________________
______________________________________________________________

Label:
Name
DOB