RELEASE TO OBTAIN RECORDS

FamilyCare Specialists™

Comprehensive Healthcare With A Caring Touch.

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Patient Name:	Date of Birth:
Home Phone:	Work Phone:
This authorization will expire on the following date or event:	

Name of organization/person providing the information:	Name of organization/person receiving the information:
Address	Address: FamilyCare Specialists 1300 Old Weisgarber Rd Knoxville, TN 37909
City: State: Zip:	City: State: Zip:
Phone #:	Phone #: (865) 584-2146
FAX #:	FAX#: (865) 584-9660

Please give a specific description of the information you want released, including dates:

Read and Initial ______

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

Read and Initial______

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will be effective from the date it is received and will not apply retroactively.

Signature of patient or patient's representative:	Date:
Printed name of patient's representative:	Relationship to the patient:

For Office Use Identification Type	Employee Signature:

TO BE COMPLETED ONLY IF REQUESTED BY THE HEALTHCARE PROVIDER.

The provider must complete the following statement:

Will the healthcare provider receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes___ No___

The patient must read and initial the following statement:

I understand that I get a copy of this form after I sign it. Initial______________