Knoxville Psychiatry
Julia wood, MD Allen Rigell MD Ginger Lovingood MD
310 N. Forest Park Blvd. Suite 202
Knoxville, TN 37919
Phone: 865-539-2221 Fax: 865-539-5324

AUTHORIZATION FOR RELEASE OR EXCHANGE OF INFORMATION

TO: _____

ADDRESS: _____

FAX: _____

REGARDING TREATMENT OF: _____

I HERBY AUTHORIZE AND REQUEST YOU TO ____RELEASE TO OR ___RECEIVE FROM:
Knoxville Psychiatry

Protected/Sensitive Health information to be disclosed below:

___History/Physical
___Laboratory Reports
___Emergency Department records
___Entire record
___Medication_____
___Discharge Summary
___Radiology Reports
___Consultation records
___Operative reports
Other:_____

___Information contained in the Patient's medical records related to psychiatric and/or psychological diagnosis, status, symptoms, prognosis, and treatment to date.
___Information contained in the Patient's medical records related to treatment for alcohol and/or drug abuse.
__HIV information and/or Aids

THE INFORMATION TO BE DISCLOSED WILL BE USED FOR THE FOLLOWING:
CONTINUATION/COORDINATION OF CARE

I understand that I have the right to revoke this authorization, in writing, at any time by notifying the Privacy Official.
This would not affect any actions already taken based upon this authorization.
I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under law
- Refuse to sign this authorization

Name of Patient:_____

Social Security #:_____DOB:_____

Patient Signature:_____**Date Signed**_____
This authorization will expire one year from date of signature or unless revoked
For personal representative (if applicable):
Print name of personal representative:_____
Describe relationship:(Parent, Guardian, power of attorney, etc.)

I hereby certify that I have the legal authority under applicable law to make this request on behalf of the patient identified above.
Signature of personal representative:_____Date:_____

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Patient Name:_____

Please list individuals involved in your health care that we may contact and/or discuss your care:

NAME	RELATIONSHIP	PHONE NUMBER

I authorize Dr. Allen Rigell, Dr. Julia Wood, Dr. Ginger Lovingood and staff at Knoxville Psychiatry to contact me and if necessary, leave medical information pertaining to my care by the following methods. I assume responsibility for notifying them whenever information changes.

Address:_____ Yes No

Home Phone:_____Cell Phone_____ Yes No

Work Phone:_____Leave Message_____ Yes No

EmailL:_____Text Message:_____ Yes No

PATIENT SIGNATURE:_____DATE:_____