**UNIVERSITY PEDIATRIC UROLOGY, PC**
**2100 W. CLINCH AVENUE, SUITE 120**
**KNOXVILLE, TN 37916**
**PHONE: 865-637-7290 FAX: 865-637-7289**

# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**(All sections must be completed)**

I hereby authorize_____ _____
and its physicians employees and agents to release or disclose to the below-named recipient all medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

I hereby authorize the release of medical records to: _____

_____

_____

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event may not exceed one year

This request and authorization applies to:

_____ All medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

_____ Specific records to be released (eg. Labs, imaging reports, other):

_____

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

_____Substance abuse _____ Psychological or psychiatric treatment ____HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient