KCBC
Knoxville Comprehensive Breast Center

Patient ID: _____

RELEASE OF PATIENT HEALTH INFORMATION

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that if my health information is used or disclosed as I am requesting, the released information may no longer be protected by privacy regulations issued by the federal government.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: _____

I request that the Knoxville Comprehensive Breast Center (KCBC) release copies of my medical records to:

☐ **Myself** or my personal representative.

☐ **Other persons or facilities** authorized to **receive** the information:

Name: _____

Address: _____

SPECIFIC DESCRIPTION OF INFORMATION TO BE RELEASED:

Dates of service/exam type: _____

Type of Information (check all that apply): ☐ Report(s) ☐ Images on CD ☐ Films

The patient or the patient's representative must read and initial the following statements:

- I understand that this authorization will expire 6 months for the date of the request. Initials: _____
- I understand that I may revoke this authorization at any time by notifying KCBC in writing, but if I do revoke it, the revocation will not have any effect on any actions KCBC took before receiving the revocation. Initials: _____

_____ _____

Signature of Patient or the patient's representative **Date**

Printed name of patient or representative: _____

If representative, relationship to the patient: _____

_____ _____

Authorizing Signature (KCBC Employee) Date

For KCBC office use:

☐ Released records as requested

☐ Request denied due to: ___ Information was compiled for civil, criminal or administrative actions.
___ Was not performed by KCBC
___ Professional decision that this information may be harmful to the patient.

Records copied and sent by: _____ Date: _____

Request denial, patient notified by: _____ Date: _____