Allergy, Asthma & Immunology Center (AAIC)
Phone: 865-273-0008 Fax: 865-895-4090

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO AAIC

Patient Name: ____ DOB: __________________________

Patient Phone Number: ______________________________________ SSN (last 4): ____________________

Patient Address: ____

I am authorizing and requesting that copies of my medical records be RELEASED from:

Name of Provider/Clinic/Organization:	Provider Phone:
Provider Fax Number:	Provider Address:

I would like my records to be released by (check one):

☐ Mail ☐ Fax

For the reason of (check all that apply):

☐ Personal Request by Patient ☐ Insurance Carrier Request ☐ Workers Compensation
☐ Continuity of Medical Care ☐ Attorney or Legal Request ☐ Other (please describe)

To be released to:

Name of Provider/Clinic/Organization: **Allergy, Asthma & Immunology Center**	Provider Phone: **865-273-0008**
Provider Fax Number: **865-336-8404** (ATTN: Medical Records)	Provider Address: 616 W Lamar Alexander Pkwy Maryville, TN 37801

I AUTHORIZE the following information to be disclosed (check any that apply, or check ALL records):

☐ Any and ALL records
☐ Records regarding treatment for the following condition(s): ____
____
☐ Records covering the date range of ____________________ to __________________________

I understand that I have the right to revoke this authorization in writing at any time by sending written notification to the Privacy Officer, Allergy, Asthma & Immunology Center, 6701 Baum Dr, Ste 140, Knoxville, TN 37919. I understand that I have the right to refuse to sign this form and my refusal will not result in AAIC conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this form, if it is for disclosure of information created for research that includes treatment, may result in AAIC declining to provide the research-related treatment. 2. Refusal to sign this release, if it is for disclosure of information to a third-party, may result in AAIC declining to provide healthcare which for the sole purpose of creating protected health information for disclosure to a third party. I understand this authorization will expire in one-year time from the signing of this form. The information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA.

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PATIENT OR AUTHORIZED PATIENT REPRESENTATIVE SIGNATURE DATE