KNOX COUNTY SCHOOLS
Human Resources
Phone: (865) 594-1929 Fax: (865) 594-3758

AUTHORIZATION AND REQUEST OF PROTECTED HEALTH INFORMATION (PHI) MENTAL HEALTH

Patient Name:	Date of Birth:	Social Security No.

Provider's Name:	Requester's Name/Address:
Provider's Address:	**KNOX COUNTY SCHOOLS** **P.O. Box 2188** **912 South Gay Street** **Knoxville, TN 37901-2188** ☐ **Health Services** ☐ **Human Resources** ☐ **ADA/504** ☐ **Sick Bank**

Covering the period(s) of health care:

From (date): To (date):

Purpose of Disclosure:

Information to be disclosed (check as many as appropriate)

___ History and physical examination
___ Treatment notes
___ Consultation report
___ Admission notes
___ Progress (visit) notes
___ Discharge notes
___ Medication
___ Oral exchange of information
___ Written exchange of information
___ Fax

_____ **(Initials)** I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, and mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records.

I understand that:

1. I may refuse to sign this authorization and doing so voluntary.
2. If I do not sign this form, my health care and the payment for my health care will be not affected unless stated otherwise.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient	**Date:**
Print Name	**Relationship to Patient:**
Witness	**Date:**