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1107 Charles G. Seivers Blvd., Clinton, TN 37716 Phone: (865) 463-2543 Fax: (865) 269-4948

**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number (last four digits): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I have been referred to OHS by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print company name) for evaluation and that the information provided by me throughout the course of my visit today may not be kept confidential, but released to the Designated Employer Representative of the above-named company as it relates to my current or potential position with this company.

\_\_\_\_ Yes \_\_\_\_No I authorize the release of my medical records to the Designated

Employer Representative of the above-named company as it

pertains to the purpose of this visit.

Patient Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Signed: \_\_\_\_\_\_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Workers’ Compensation is exempt from HIPAA regulations per section 279 (c)(1) of PHS Act 42 U.S.C. 300gg-91 (c)(1).