University Center for Pain Management
UCPM of knoxville
reclaim relief & function

Medical Record Request

From Outside Facility

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION Date: _____

I hereby authorize the following practice to release medical records

Practice Name _____ Phone: _____

Address _____ Fax: _____

_____

For the Following Patient

Patient Name: _____ Date of Birth: _____

Address: _____ Phone No: _____

City: _____ State: _____ Zip Code: _____

Covering the period(s) of health care from _____ to _____

Release the following information:

- ☐ Complete Medical Record(s)
- ☐ Discharge Summary
- ☐ History and Physical Exam
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Radiology CD

To be released to

University Center for Pain Management of Knoxville
c/o Medical Records
1934 Alcoa Hwy., Building D, Suite 474
Knoxville, TN, 37920
Fax (865) 305-8695

Reason for Release _____

You have the right to revoke this authorization by doing so in writing and mailing to the medical records department at:

University Center for Pain Management of Knoxville
c/o Medical Records
1934 Alcoa Hwy., Building D, Suite 474
Knoxville, TN, 3792

Such revocation will be effective to the extent that action has not been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy. I am also aware that this authorization expires in **90 days**. I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that my refusal will not affect my eligibility for benefits, payment for coverage of services, or ability to obtain treatment. The information used or disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.

_____ _____
Signature Last 4 of Social

_____ _____
Printed Name (Relationship to Patient) Todays Date