Dear Patient:

Thank you for contacting **University Urology, PC** Medical Records Department. To better serve you with your request for medical records, **University Urology, PC** has partnered with Sharecare Health Data Services. Sharecare Health Data Services will fulfill your request for records in a safe, secure, and timely manner.

In order to receive a copy of your records, you will need to complete and return the attached Authorization form.

- Please make sure you have specific instructions included as to **what** records you are requesting and **where** you are requesting they be sent.
- You also have a choice of **how** you would like to have your records delivered. For records to be delivered directly to you, please choose mail or email. For records to be delivered to another doctor, please choose fax or mail. Please select only one option. The fax delivery option may only be used for records going to a doctor.

Please mail/fax/drop-off the completed Authorization form to University Urology, PC. *The fax number is 865-305-4589.*

For Records being sent to Another Health Care Provider

Please provide as much contact information for your other Doctor, including the address, phone & fax.

You can contact a Sharecare Health Data Services representative at any time by calling:

1-877-391-9890.

Thank you,

Medical Records Supervisor
University Urology, PC

University Urology, PC

Authorization to Disclose Protected Health Information

The undersigned authorizes:

University Urology, PC
University of Tennessee Medical Center
1928 Alcoa Highway
Building B, Suite 222
Knoxville, TN 37920
Ph. 865-305-9254 | Fax. 865-305-4589

To release/obtain my health information as noted below:

Patient Information

Patient Full Name:_____ **Other Names?** _____

Patient Address:_____ **Date of Birth:** _____

City:_____ State:_____ Zip:_____ Phone #: _____

Release Information To

Name/Facility:_____ **Attention:** _____

Address:_____ **Phone:** _____

City:_____ State:_____ Zip:_____ **Fax #:** _____

Email:_____ *(Please ensure email address is legible!)*

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Please forward Records by: ☐ Mail ☐ Fax (for Dr's Offices) ☐ Email

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year abstract** of my records
Abstract includes most recent notes, labs, procedures & testing.
☐ Please release a **2 year abstract** of my records
☐ **Date Range**:_____:
□ Progress Notes □ Radiology Reports □ Labs
□ Operative Reports □ Physical Therapy Notes
□ Other:

Should you have any questions regarding how to complete Authorization, please contact Sharecare Health Data Services at:

877-391-9890

sharecare | HEALTH DATA SERVICES
Formerly BACTES

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.* _____ *(Please Initial)*

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition:**_____**.** *If I do not specify expiration this authorization will expire in 90 days.*
4. If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, or if protected information is not released, we may be unable to fulfill this request.

Signature*:_____ **Date:** _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*