AUTHORIZATION FOR THE RELEASE OF INFORMATION

RECORDS OF: _____

D.O.B.: _____ S.S.N.: _____ D.O.L.: _____

I hereby authorize_____,
and to its representative Knox Attorney Service, Inc./ Knox Services LLC., to inspect and make copies of:

_____ 1. All medical and hospital records in your possession or under your control pertaining to any examination and/or treatment rendered to the above-named person(s).

_____ 2. All employment, health, personnel, pay records and employment applications pertaining to the above-named person(s).

_____ 3. All accident reports and all other accident records and/or investigation reports pertaining to an accident of _____, involving the above-named person(s).

_____ 4. Any and all records, reports, notes, papers, correspondence, etc., pertaining to claim file number_____, pertaining to the above-named person(s).

_____ 5. Any and all scholastic files and records including, but not limited to registration, courses of study and curriculum, attendance, scholastic achievements, results of examinations, transcripts, financial aid records, counseling records, student health and nursing records of said student.

for the period of: _____ thru _____

This information is required for:

_____

REASON FOR DISCLOSURE

I authorize **KNOX** a private photocopy company, to photocopy such records as are needed for the above stated purpose.

I have read the above and also have been advised of my right to receive a true copy of this authorization. Further I understand the contents of this written authorization in its entirety and have asked questions about anything that was not clear to me and I am satisfied with the answers I have received.

A PHOTOSTATIC OR FACSIMILE COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

Signature_____

Date_____ Copy Furnished: YES: ☐ NO: ☐

EXPIRATION DATE: _____

IF APPLICABLE, PLEASE COMPLETE THE FOLLOWING:

I hereby consent to the release of any and all records related to the treatment of, or diagnosis for, Drug, Alcohol, Psychiatric, HIV/Aids Related conditions under the same terms as outlined above. I understand that such information cannot be released without my specific consent.

Signature of Patient:

_____ Date:_____

_____

Signature of person acting on behalf of Patient

Relationship to Patient:

_____

(If an appointed Guardian, please attach documentation)

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

Authorized Agent:
Knox Attorney Service, Inc., Knox Services LLC.