AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____________________________ Date of Birth:__________________

Patient Address:____
Street

____
City, State and Zip Code

Request records from:____

____

I AUTHORIZE RELEASE OF PROTECTED HEALTH INFORMATION AS NOTED BELOW. Please send the following Protected Health Information for the period:

_____/_____/_______ to ______/______/_____ OR _____/______/_____only.

- ☐ Progress Notes
- ☐ X-Ray Reports
- ☐ Hospital Records
- ☐ Other (specify)____________________________________
- ☐ Lab Reports
- ☐ All available records

PURPOSE OF RELEASE ☐CONTINUUM OF CARE ☐INSURANCE ☐BILLING ☐LEGAL

☐ OTHER (LIST) ____

RELEASE INFORMATION TO: Attention:______________________________

ARTHRITIS ASSOCIATES
1035 EXECUTIVE DRIVE
HIXSON, TN 37343
PH: (423) 826-0800
FAX: (423) 826-0810

THIS AUTHORIZATION WILL EXPIRE ON________________ OR NO LONGER THAN 90 DAYS FROM DATE SIGNED. I FURTHER UNDERSTAND I MAY REVOKE THIS AUTHORIZATION AT ANY TIME EXCEPT TO THE EXTENT ACTION HAS ALREADY BEEN TAKEN. TO REVOKE AUTHORIZATION, A SIGNED, WRITTEN REQUEST MUST BE PRESENTED IN PERSON OR BY CERTIFIED MAIL TO THE ATTENTION OF THE PRIVACY OFFICE OF THIS INSTITUTION. I UNDERSTAND I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION. ARTHRITIS ASSOCIATES WILL NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS ON WHETHER I PROVIDE THIS AUTHORIZATION. I UNDERSTAND MY RECORDS MAY BE SUBJECT TO DISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS. I UNDERSTAND THIS AUTHORIZATION DOES NOT LIMIT ARTHRITIS ASSOCIATES OR IT'S EMPLOYEES' OR AGENTS' ABILITY TO USE OR DISCLOSE MY INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, OR AS OTHERWISE PERMITTED BY LAW.

_______________________________________ ________________________
Signature of Patient or Legal Rep. **Date**

_______________________________________ ________________________
PRINT NAME OF PATIENT OR LEGAL REP. **RATIONALE FOR SERVING AS LEGAL REP.**
(i.e. parent, legal guardian, power of attorney)