Knoxville Rheumatology PLLC

Authorization for Release of Medical Records

I hereby authorize Knoxville Rheumatology PLLC (Dr. Mishal Abdullah) to release health information on;

_____ _____

Name of Patient **Date of Birth of Patient**

_____

Address

_____ _____

City, State, Zip **Contact Number**

For Healthcare covering the period(s) from (date) _____ to (date) _____

The purpose of this disclosure is for:

__ **Continuation of Medical Care** __ **Attorney Review** __ **Insurance Purposes**

__ **Other**_____

Information to be disclosed may include:
__ Copy of all health records to **include** HIV testing/results, mental health and/or alcohol or drug abuse records
__ Copy of all health records to **exclude** HIV testing/results, mental health and/or alcohol or drug abuse records
__ Specific records: Progress Notes ___ Laboratory Tests ___ Radiology Reports ___ Other _____

I understand that the information released as a result of this Authorization for Release of Protected Health Information (PHI) may be subject to re-disclosure and no longer protected by federal or state laws applying to medical information release.

I understand that there may be a fee for copying my medical records it is to be used for other than continuance of healthcare with another provider.

I understand that this Authorization may be revoked in writing at any time. I understand that such a revocation will apply only to releases of information made after the date of my revocation.

Unless otherwise indication, this authorization will expire in twelve (12) months from the date of signature. A photocopy of this authorization will be considered as valid as the original. I understand that I will be provided a copy of this Authorization by Knoxville Rheumatology PLLC upon request.

Address: 2072 Lakeside Center Way, Knoxville, TN 37922 www.knoxrheum.com
Phone: 865-246-6580 Fax: 865-444-6196 Email: info@knoxrheum.com

Knoxville Rheumatology PLLC

I understand and agree that my medical record will be maintained in a paper or electronic medical record (EMR) format and that records may be transmitted electronically via fax, e-mail, internet, or data transfer system.

I understand that Knoxville Rheumatology PLLC cannot require me to sign this Authorization as a condition to providing services to me. I understand that I may inspect and/or copy the information to be disclosed. I understand that authorizing this disclosure is voluntary. I understand that if I have any questions about disclosure of my health information, I may contact my physician or Knoxville Rheumatology PLLC's Privacy Officer.

TO:

(This section will be filled out in case your records need to be sent to another physician. Please only sign and date)

Physician Name: _____

Address: _____

Phone: _____ **Fax:** _____

Signature of Patient _____ **Date** _____

_____

(Relationship or status if signed by anyone other that patient, parent or legal guardian, personal representative, etc.)

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