Knoxville Rheumatology PLLC

Authorization to Request Medical Records

_____

Patient's Name and Date of Birth

_____

Patient's Signature and Date

_____

Information Requested

_____

Reason for Request

I request that mine or my child's complete records or specific information as listed above be released to:
Knoxville Rheumatology PLLC
2072 Lakeside Center Way
Knoxville, TN 37922
Phone: 865-246-6580
Fax: 865-444-6196

_____

Physician or Practice Name

_____

Address

_____

Phone Number and Fax Number

By signing this form, I authorize you to request confidential health information about me or my child. I understand that 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 the facility receiving the revocation.

If the requestor or receiver is not a health care plan or healthcare provider, the released information may no longer be protected by federal privacy regulations or may be redisclosed.

I have read and authorize the disclosure of the protected health information as stated. I may receive a copy of this form after I have signed it.