TENNESSEE VEIN CENTER

AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the disclosure of my medical information as described below. I understand that the information disclosed under this authorization may be subject to re-disclosure by the recipient.

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

City/State/Zip _____

INFORMATION TO BE DISCLOSED:

☐ Complete Health Records, or ONLY THOSE CHECKED BELOW:

☐ History and Physical Examinations ☐ Consultation Reports ☐ Progress Notes

☐ Procedure Notes ☐ Laboratory Tests ☐ Radiology/Ultrasound Images

☐ Radiology/Ultrasound Reports ☐ Photos ☐ Billing/Financial Records

☐ Other _____

_____ (Initials) I specifically consent to the release of any information related to testing and treatment for HIV, AIDS, mental health/psychiatric care, or alcohol and/or drug abuse if such is contained in the medical records. This provision must be initialed by the person giving consent or this information will not be released.

THIS INFORMATION IS TO BE DISCLOSED FROM:

Name: _____

Address: _____

City/State/Zip: _____

Fax: _____

THIS INFORMATION IS TO BE DISCLOSED TO:

Tennessee Vein Center
431 Marilyn Lane
Alcoa, TN 37701
Fax: (865) 233-5870

For the purpose(s) of: _____, or

☐ At the request of the individual

AUTHORIZATION SIGNATURES:

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire ninety (90) days from the date signed below.

Signed: _____ _____
Patient Date

Signed: _____ _____
(or) Legal Representative Date

Signed: _____ _____
Witness Date