ARTHRITIS ASSOCIATES OF KINGSPORT, PLLC
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PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____

Date of Birth: _____

By signing this authorization, I authorize Arthritis Associates of Kingsport to use, disclose, or receive certain protected health information (PHI) about me to or for the party or parties listed below, including all medical records, labs, scans, diagnostic testing, EMG, MRI, CT, etc. This authorization permits Arthritis Associates of Kingsport to use, disclose, or receive health information from/to:

_____

_____

_____

When my information is used or disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by the HIPPA privacy rule. I have the right to revoke this authorization in writing. My written revocation must be in writing to:

ARTHRITIS ASSOCIATES OF KINGSPORT, PLLC
THREE SHERIDAN SQUARE
KINGSPORT, TN 37660

Patient signature/Representative: _____

Date: _____ Expiration Date: _____

Witness: _____