Tristate Arthritis & Rheumatology, P.S.C.

Arthur M. Kunath, MD
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Joseph E. Temming, MD
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Malini Juyal, M.D.

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SS#

STREET ADDRESS CITY STATE ZIP

DATE OF BIRTH DAY PHONE # EVENING PHONE #

INFORMATION RELEASED FROM:	INFORMATION RELEASED TO:
Name of Dr. or Clinic: _____	Name: _____
Address: _____	Address: _____
_____	_____

DATE BY WHICH INFORMATION IS NEEDED: _____

PLEASE INDICATE INFORMATION TO BE DISCLOSED:

_____ Progress Notes	_____ Laboratory Reports	_____ Hospital Records
_____ Dexa Scan Reports	_____ Radiology Reports	_____ Therapy Reports
_____ MRI Reports	_____ EMG Reports	_____ Xray Reports

_____ Complete Copy of All Medical Records

OR ____ Any and all medical records including chemical dependency/drug or alcohol abuse treatment records.

OR ____ Any and all medical records, billing records and secondary records, chemical dependency/drug or alcohol abuse treatment records.

ALL RECORDS PERTAINING TO PSYCHIATRIC/MENTAL HEALTH AND/OR HIV/HIV RELATED ILLNESSES WILL BE RELEASED UNLESS INDICATED HERE:

_____ Do Not Release Records Related to Mental Health and/or HIV

THIS INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF:

_____ Medical Care	_____ Legal Reason
_____ At My Request/Personal Reasons	_____ Insurance
_____ Disability	_____ Other _____

THIS IS YOUR "FREE COPY." If you need to give these records to anyone else, please make copies for yourself.

_____ (Patient's Initials)

Authorization expiration date or event _____. If left blank, will expire one year from date of signature.

I understand that if the person/entity that receives the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be redisclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. I understand I may revoke this authorization in writing at any time. Written revocation must be sent to: Tristate Arthritis & Rheumatology, Attn: Medical Records Department, 2616 Legends Way, Crestview Hills, KY 41017.

Patient Signature / Legal Representative* Date

*Provide Guardianship, Executor of Estate, Power of Attorney