



Kerrin D. Burte, MD
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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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Hospital Records |
| <input type="checkbox"/> Dexa Scan Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Therapy Reports |
| <input type="checkbox"/> MRI Reports | <input type="checkbox"/> EMG Reports | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> 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:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Legal Reason |
| <input type="checkbox"/> At My Request/Personal Reasons | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Disability | <input type="checkbox"/> 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 re-disclosed 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