Tristate Arthritis & Rheumatology
Quality Compassionate Care

Kerrin D. Burte, MD
Joseph E. Temming, MD
Liza R. Varghese, MD
C. Lee Colglazier, MD
Malini Juyal, MD
Drew Huffman, DO

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	_____	X-ray 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 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