Milligan Vein

1919 Pinnacle Point, Knoxville TN 37922

Authorization to use/disclose or receive Private Health Information

I (Please Print Your Name):

Authorize **MILLIGAN VEIN** to use / disclose or receive the following Private Health Information concerning:

Please Print Patient's Name:

Patient's Date of Birth: / / | Patient's Soc. Sec. #: - -

Please indicate what information that may be disclosed or received

OP NOTES ☐ **OFFICE VISITS** ☐ **LAB WORK** ☐

X-RAY ☐ **OTHER** _____

Please list the reason for disclosure:

If the information to be disclosed contains any records related to the types of information below, additional laws regarding use and disclosure may apply. I understand and agree that this information will be disclosed only if I place my initials in the applicable box below:

HIV/AIDS Information ☐ Drug/Alcohol diagnosis, treatment, or referral information ☐

Genetic testing Information ☐ Mental health Information ☐

Please tell us the range of dates we may release or receive: FROM: TO:

MILLIGAN VEIN may disclose this information to:

NAME AND ADDRESS PLEASE:

Please list fax # if requested information is to be faxed:

MILLIGAN VEIN may receive information from:

NAME AND ADDRESS PLEASE:

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of all or some of this information including HIV/AIDS, mental health, genetic testing and drug/alcohol diagnosis, treatment or referral information.

You are not obligated to sign this authorization and refusing to do so will not adversely affect your ability to receive health care services unless the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described may no longer be used or disclosed for the purposes in this written authorization; however, any use or disclosure made prior to any revocation cannot be undone. To revoke this authorization, please send a written statement to Attn: Compliance Office, Milligan Vein, 1919 Pinnacle Pointe , Knoxville, TN 37922. This authorization will expire in one year unless you revoke it sooner or list an expiration date or event below.

I have read this authorization and I understand it:

Signature _____ Today's Date _____

Relationship to patient if signing as patient representative _____ Expiration Date or event. If blank, valid for 1 year from today's date. _____

Crossville
1720 West Ave, Crossville, TN
38555
931.787.1940