Chang-Wen Chen M.D., P.C.
10430 Lovell Center Drive
Knoxville, TN 37922
P-(865)-693-6620
F-(865)-693-2909

MEDICAL INFORMATION RELEASE AUTHORIZATION FORM

Patient Name: _____ **Patient DOB:** _____

Patient's Last 4 of SSN: _____

I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information (''PHI'') described below to my physician, ***CHANG-WEN CHEN M.D., P.C.***

This authorization also releases my physician, ***CHANG-WEN CHEN M.D., P.C.*** to release any of my medical records needed to secure referrals with specialists he feels I need to see to maintain my health.

This Authorization for release of PHI covering the period of health care.

☑ **All past, present and future periods.**

I hereby authorize the release of PHI as follows

☑ **My complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol/drug abuse).**

In addition to the authorization for release of my PHI described in paragraphs above of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

Name _____ **Relationship** _____
Name _____ **Relationship** _____
Name _____ **Relationship** _____

This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or until I transfer to another physician at which point the new physician will need to send us a signed release

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

Sign: _____ **Date:** _____