THE VEIN COMPANY, LLC
310 N State of Franklin Rd, Ste 103 Johnson City, TN 37604
6 Sheridan Sq, Ste 100 Kingsport, TN 37660
328 Cummings St, Ste A Abingdon, VA 24210
4327 W Andrew Johnson Highway, Ste 4 Morristown, TN 37814
1229 Fox Meadows Blvd, Ste 2 Sevierville, TN 37862
1400 Dowell Springs Blvd, Ste 100 Knoxville, TN 37909
800 Oak Ridge Turnpike, Ste C 260 Oak Ridge, TN 37830
7305 Jarnigan Rd, Ste 260 Chattanooga, TN 37421

Medical Records Release

PLEASE FAX TO: 423-491-8109

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize: _____

to (please circle) OBTAIN *OR* *RELEASE* my protected health information as indicated below to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED/RECEIVED:

FROM AND TO DATES: _____

Please check what is to be released. OFFICE NOTES: _____ OPERATIVE NOTES: _____

RADIOLOGY REPORTS: _____ OTHER (Specify): _____

PURPOSE OF DISCLOSURE (please check)

_____ Changing Physicians/Care _____ Patient request _____ Worker's Comp _____ Second Opinion
_____ Legal _____ Insurance _____ School _____ Other (Specify) _____

1. I understand that this authorization will expire in ninety (**90**) days from the date of signed.
2. I understand that I may revoke this authorization at any time by notifying The Vein Company in writing. If I do revoke the authorization, it will not have any effect on any actions taken by The Vein Company prior to their receipt of the revocation.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal Privacy Regulations. However, other state or federal law may prohibit the receipt from disclosing specialty protected information, such as substance abuse treatment, HIV/AIDS related information, and psychiatric/mental health information.

I understand that this health information may include HIV/AIDS related information and or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

_____ HIV/AIDS related info (including AIDS related testing) _____ Substance Abuse _____ Mental/Psychotherapy Notes

BY SIGNING BELOW, I ACKNOWLEDGE/READ AND UNDERSTAND THIS AUTHORIZATION OF PHI.

_____ _____
Signature of Patient or Parent/Legal Guardian Relations to Patient

_____ _____
Signature of Employee of THE VEIN COMPANY Date