EAST TENNESSEE VASCULAR CENTER, PLLC
SHAHIN ASSADNIA, M.D.
1125 West 1st North Street, Suite B
MORRISTOWN, TN 37814
PHONE (423) 317-6560 FAX (423) 317-6570

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In keeping with HIPPA regulations, we must have the following authorization on file:

Patient's Name: _____ _____ _____
(Last) (First) (Middle)

Patient's Social Security Number: _____ - _____ - _____

Patient's Date of Birth: _____ _____ _____
(Month) (Day) (Year)

I hereby authorize the release of any medical or other necessary information to EAST TENNESSEE VASCULAR CENTER, PLLC, including the records of any treatment or examination rendered to me in the course of my diagnosis and treatment.

I hereby authorize EAST TENNESSEE VASCULAR CENTER, PLLC to release any medical or other necessary information, including the records of any treatment or examination rendered to me in the course of my diagnosis and treatment.

I hereby authorize the release of any medical or other information necessary to process my insurance claims made by the providers of EAST TENNESSEE VASCULAR CENTER, PLLC.

They may / may not leave a message at my home / work.
They may / may not give results to: _____

Signed: _____ Date: _____
(Signature of patient or authorized person)

Print Name Here:_____

Witnessed: _____ Date: _____
(Signature of Witness)

Witness Print Name Here: _____