

GREGORY BREWER, MD PLLC

RELEASE FORM TO HAVE YOUR MEDICAL RECORDS SENT TO OUR OFFICE. THEY CAN BE FAXED TO: 865-531-6587 OR MAILED TO: 314 PROSPERITY ROAD, KNOXVILLE TN 37923. OFFICE PHONE: 865-691-8011

- 1. I AUTHORIZE MY PROTECTED HEALTH INFORMATION (PHI) AS LISTED BELOW IN SECTION 2, TO BE SENT TO GREGORY BREWER, MD PLLC.
- 2. INFORMATION TO BE DISCLOSED: CHECK AS MANY AS APPROPRIATE:

\_\_\_\_\_ COMPLETE RECORDS

**OR ONLY SEND THE BELOW INDICATED SECTIONS**

\_\_\_\_\_ HISTORY & PHYSICAL EXAM      \_\_\_\_\_ OFFICE VISIT NOTES      \_\_\_\_\_ BILLING/FINANCIAL

\_\_\_\_\_ OPERATIVE NOTES      \_\_\_\_\_ LAB RESULTS      \_\_\_\_\_ REFERRAL INFORMATION

\_\_\_\_\_ IMAGING/RADIOLOGY REPORTS      \_\_\_\_\_ CONSULT REPORTS (INCLUDING INPATIENT/OUTPATIENT)

\_\_\_\_\_(INITIALS) I SPECIFICALLY CONSENT TO THE RELEASE OF ANY INFORMATION RELATED TO TESTING AND TREATMENT OF HIV, AIDS, MENTAL HEALTH/PSYCHIATRIC CARE, OR ALCOHOL AND/OR DRUG ABUSE IF SUCH IS CONTAINED IN THE MEDICAL RECORDS. THIS PROVISION MUST BE INITIALED BY THE PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

- 3. INFORMATION TO BE RELEASED FROM THE BELOW PERSON(S)/ORGANIZATION(S):

PHYSICIAN NAME (PLEASE PRINT)

PHONE NUMBER/ADDRESS

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4. REASON FOR RECORDS REQUEST: \_\_\_\_\_ OR INITIAL HERE IF AT YOUR REQUEST \_\_\_\_\_.

5. THIS AUTHORIZATION WILL EXPIRE NO LATER THAN (1) YEAR FROM TODAY. I UNDERSTAND THAT THIS AUTHORIZATION MAY BE REVOKED IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. IF YOU CHOOSE TO HAVE THIS AUTHORIZATION EXPIRE SOONER THAN (1) YEAR, PLEASE INDICATE THE DATE YOU WANT THE AUTHORIZATION TO EXPIRE: \_\_\_\_\_

6. IN THE EVENT THAT MY INFORMATION HAS ALREADY BEEN SHARED BY THE TIME MY AUTHORIZATION IS REVOKED, IT MAY BE TOO LATE TO CANCEL PERMISSION TO SHARE MY HEALTH DATA.

PRINTED PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

PATIENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

IF GUARDIAN, DOCUMENTATION IS REQUIRED TO VALIDATE ALL PAPERWORK.

OFFICE STAFF WITNESS SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_