AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below.

Patient Name _____ Address _____

Date of Birth _____ Telephone _____

Covering the period(s) of health care:

From (date) _____ To(date) _____, and

2. Information to be disclosed (check as many as appropriate):

___Complete health record(s), OR ONLY:

___History & Physical Examinations ___Consultation Reports

___X-Ray Reports ___Billing/Financial ___Progress (Visit) Notes ___Laboratory Tests___Photos, Tapes, X-Rays or Any Images

3. _____(Initials) I specifically consent to the release of any information related to testing and treatment for 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 PERSON GIVING CONSENT OR THIS INFORMATION WILL NOT BE RELEASED.

4. This information is to be disclosed to:

Gallian Medical Group
10744 Hardin Valley Rd. Ste. 106
Knoxville, TN 37932 Knoxville, TN 37932
Tel-865-357-3790 Fax-865-357-3355

From previous physician name and phone number:

_____
_____
_____
_____

for the purpose(s) of: _____, or. ❑ At the request of the patient

5. This authorization will expire on _____, not to exceed 1 year. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. If I fail to specify a date or otherwise revoke this authorization, this authorization will expire forty-five (45) days from the date signed below.

6. I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of Healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Signed:

Patient _____ (OR) Legal Representative _____

Date _____

Witness _____ Date _____