

# AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION

1. I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed under this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations:

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 (name & address): This information is to be disclosed by (name & address):

**Gallian Medical Group,**  
**10744 Hardin Valley Rd. Suite 106**  
**Knoxville, TN 37932**  
**Tel:865-323-7223 Fax: 865-247-5371**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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 \_\_\_\_\_

Date \_\_\_\_\_

(OR) Legal Representative \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_