**GREGORY BREWER, MD PLLC**

**RELEASE FORM TO HAVE YOUR MEDICAL RECORDS SENT FROM OUR OFFICE TO ANOTHER PHYSICIAN.**

1. **I AUTHORIZE THE USE/DISCLOSURE OF MY HEALTH INFORMATION AS LISTED BELOW. I UNDERSTAND THE INFORMATION DISCLOSED UNDER THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULARIONS.**
   **PRINT PATIENT NAME: _____ DOB: _____**
   **ADDRESS: _____ PHONE: _____**
   **_____**

**COVERING MY MEDICAL RECORDS FROM DATE: _____ TO DATE: _____ AND:**

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)**

3. **_____(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.**

4. **I AUTHORIZE GREGORY BREWER, MD PLLC TO SEND MY ABOVE INDICATED INFORMATION TO THE BELOW LISTED PARTIES (NAME AND ADDRESS):**

   **PHYSICIAN NAME (PLEASE PRINT) PHONE NUMBER/ADDRESS**

   **_____**

   **_____**

   **_____**

**FOR THE PURPOSE OF: _____ OR**

☐ **AT THE REQUEST OF THE PATIENT IF CHECKED HERE.**

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

**PRINTED PATIENT NAME: _____ DOB: _____**

**PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____**

**OFFICE STAFF WITNESS SIGNATURE: _____ DATE: _____**