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 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 RECIPEINT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULARIONS.

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. 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: ___________________

5. I UNDERSTAND THAT I HAVE A RIGHT TO REFUSE TO SIGN THIS FORM AND THAT MY REFUSAL WILL NOT RESULT IN THE PHYSICIAN LIMITING MY HEALTHCARE WITH (2) EXCEPTIONS. (1). REFUSUAL TO SIGN THIS AUTHORIZATION IF IT IS FOR DISCLOSURE OF INFORMATION CREATED FOR RESEARCH THAT INCLUDES TREATMENT, MAY RESULT IN THE PHYSICIAN DECLINING TO PROIVDE THE RESEARCH RELATED TREATMENT. (2). REFUSAL TO SIGN THIS AUTHORIZATION IF IT IS FOR DISCLOSURE OF INFORMATION CREATED FOR THE SOLE PUROSE OF DISCLOSURE TO A THIRD PARTY, MAY RESULT IN THE DOCTOR DECLINING TO PROVIDE THE HEALTHCARE WHICH IS THE SOLE PURPOSE OF CREATING PROTECTED HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY. (FOR EXAMPLE, IF THE PHYSICIAN WAS ASKED TO PERFORM AN INDEPENDENT MEDICAL REVIEW FOR AN ATTORNEY DUE TO A LAWSUIT).

6. I AUTHORIZE THE BELOW PHYSICIAN/OFFICE/PRACTICE/ETC., TO SEND MY ABOVE INDICATED INFORMTION TO GREGORY BREWER MD, PLLC

   PHYSICIAN NAME (PLEASE PRINT) PHONE NUMBER/ADDRESS

   ____

   ____

   ____

   ____

PRINTED PATIENT NAME: ____ DOB: _____________________

PATIENT/GUARDIAN SIGNATURE: ____________________________________ DATE: ____________________

OFFICE STAFF WITNESS SIGNATURE: __________________________________ DATE: _____________________