



Baptist Eye Surgeons, PLLC

Medical Records Release – Patient Authorization for Use/Disclosure of Protected Health Information

Patients Name: _____ Date of Birth: _____

Patients Address: _____

Email Address: _____

I, the undersigned patient or legal representative, hereby authorize Doctor _____ (Provider) to release my entire medical record or designated portions in provider’s possession to _____ for all dates of service indicated.

I understand that my decision to sign this form is voluntary, and the provider may not condition treatment, payment, enrollment or eligibility for benefits whether I sign this authorization. I understand that I may revoke this authorization, in writing, at any time by following the directions in the Provider’s Notice of Privacy Practices, except to the extent that the provider has already acted, based on this authorization.

I understand this authorization shall expire, without my express revocation, 60 days from the date written below. I understand that the information disclosed under this authorization may no longer be protected by HIPAA privacy regulations and may be subject to redisclosure by the recipient. A photocopy or facsimile of this form shall be valid as the original.

Dates of service to release: _____

____ This release is being made at my request, for the purpose of transferring my care

____ The entire medical record is being requested

**** Psychiatric records or infectious diseases (i.e. HIV, Hepatitis C, TB, etc.) must be clearly marked or checked before they will be released and MUST be physician approved.**

The following portions of the Medical Record are being requested or approved to release:

- ____ Record/Dictation ____ History & Physical ____ Labs ____ X-Ray Reports
- ____ Pathology Report ____ Doctors Orders ____ Medications ____ Itemized Bill
- ____ Other ____ Psychiatric or infectious disease records ____ Photos, digital, video images

Form/Format: ____ Paper Records ____ Fax ____ Email

*Sending medical records via email has risks, including the individuals PHI being ready or otherwise intercepted by a third party while in transit. File size may limit ability to send by email. Your records will be sent via encrypted email.

I ACCEPT THESE TERMS AND AUTHORIZE THE ABOVE DESCRIBED DISCLOSURE.

Patient Signature

Date

Patient’s Legal Representative

Date

Legal representative is authorized to act for the patient as the patient’s: ____ Parent ____ Legal Guardian ____ Other

Printed Name

Locations:

Downtown Knoxville
4528 Chapman Highway
Knoxville, TN 37920
865-579-3920 Phone
865-579-3925 Fax

West Knoxville
140 Capital Drive
Knoxville, TN 37922
865-579-3920 Phone
865-251-0730 Fax

Morristown
3001 W Andrew Johnson Hwy
Morristown, TN 37814
423-581-0360 Phone
423-585-4244 Fax