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, herby 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, Suite 110
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