East Tennessee Eye Surgeons
Dawson & Gallaher
Advanced Medicine & Surgery of the Eye

Telephone (865) 546-1464
Fax (865) 546-0470

DISCLOSURE OF PROTECTED HEALTH INFORMATION AUTHORIZATION FORM

This form, if signed, will authorize ____ to release specified protected health information about the person named below to: ____

I hereby authorize the release of protected health information relating to:

Patient Name: ____**Date of Birth:** _______________

The information to be released is: (***specify the exact information to be released, including dates of service):***
____
____

Document/Report/Study Date

- ☐ History and physical examination __________ (DOS)
- ☐ X-ray reports _________________________ (DOS)
- ☐ Operative Report _______________________ (DOS)
- ☐ Progress notes _________________________ (DOS)
- ☐ Photographs, videotapes, or digital or other images __________(DOS)

Consultation reports ___________ (DOS)
Laboratory tests _______________ (DOS)
Discharge summary ____________ (DOS)
Other: _______________________ (DOS)

I understand that the released information may include information relating to:

- ☐ Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- ☐ Treatment for drug or alcohol abuse.
- ☐ Mental or behavioral health or psychiatric care.

The information disclosed is to be sent by:

- ☐ Mail
- ☐ Fax
- ☐ Via Internet (when applicable)
- ☐ Held for pickup by: ____

I acknowledge the following statements:
I understand that I generally may revoke this authorization at any time by notification in writing of my intent to revoke this authorization. If I do notify my intent to revoke this authorization, such revocation will not have any effect on any actions by East Tennessee Eye Surgeons, PC taken before the revocation. __________ *(Initials)*
Unless otherwise revoked, this authorization will expire one year from the date of my signature. __________ *(Initials)*
East Tennessee Eye Surgeons, PC will give me a copy of this authorization form after I sign it. __________ *(Initials)*

Signature of patient or patient's legally authorized representative (***signers other than the patient must present legal documentation that authorizes them to act on the patient's behalf***)

Date: ______________________

____
Printed name of patient's representative:

____
Relationship to patient giving representative authority to act for patient