GILLIE

AESTHETICS | DERMATOLOGY

MEDICAL RECORDS RELEASE REQUEST

HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

TO: ______________________________

Name of Healthcare Provider/Clinic/Facility

____

Street Address

____

City, State and Zip Code

RE: Patient Name: ______________________________

Date of Birth: ____________________ Phone: ____________________

I authorize and expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following, to the below office, for purposes of continuing my medical care:

G I L L I E Aesthetics and Dermatology, Plc
1602 W Northfield Blvd. Suite 300
Murfreesboro, TN 37129

Phone: (615) 801-7674
Fax: (615) 281-3356

☐ All medical records, meaning **every page in my record,** including but not limited to: office notes, face sheets, history and physical, consultation notes, cosmetic therapies, inpatient, outpatient and emergency room treatment, all clinical charts, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, and photographs.

☐ All laboratory, histology, cytology, and pathology reports, radiology records and films including CT scan, MRI, MRA, EMG, echocardiogram and reports.

☐ All operative reports.

☐ All pharmacy/prescription records including NDC numbers.

☐ Health care information related to the following treatment or medical condition:____

If you do not want certain portions of your medical records released, please check the space below indicating the information you do not want released :

☐ Substance or alcohol abuse ☐ Psychiatric Treatment ☐ HIV/AIDS

I understand the following regarding this authorization:

The medical and cosmetic information disclosed in this authorization may be used by the providers of G I L L I E Aesthetics and Dermatology, Plc for my medical treatment and consultation of any other purposes as I may direct.

I may revoke this authorization in writing at any time addressed to G I L L I E Aesthetics and Dermatology, Plc, 1602 W Northfield Blvd, Suite 300, Murfreesboro, TN 37129. My revocation will not apply to information already released, used, or disclosed in response to this authorization.

This authorization will be in effect for **one year from date of signature** or until _____________________________ (date) at which time this authorization expires.

I understand any disclosure of information carries the potential for any unauthorized disclosure which may not be protected by Federal confidentiality laws.

The information authorized in this release may contain records that indicate the presence of communicable and non-communicable diseases, including alcoholism, drug related conditions, psychological conditions, and blood-borne infectious diseases subject to Federal or state restrictions on disclosure. I understand drug and alcohol abuse treatment records represent a category of medical information protected by Federal Confidentiality Rules (42CFR2.31). I have specifically considered this information and hereby wave these restrictions to allow disclosure of any such records included in my released health information.

My continued medical treatment does not depend upon whether I sign this authorization. If I refuse to sign this release, the above named office may not condition future treatment.

I have read and fully understand these provisions. I personally request this transfer of my medical records for the purpose and extent stated above.

Patient or Representative Signature: _______________________________________

Relationship to Patient: ____

Printed Name: ________________________________ **Date:** ___________________