GILBERT GHEARING, M.D.
P.O. Box 158, Celina, TN 38551 phone 931-243-5259 fax 931-243-5156 GhearingMD.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____ **SS#** _____

ADDRESS: _____**CITY:** _____ **ST:** _____ **ZIP:**_____

MOBILE PHONE: (_____)_____-_____ **OTHER PH:** (_____)_____-_____

I hereby authorize the office of Gilbert Ghearing, M.D., to release information from my medical record as indicated below to:

_____
Name of physician, clinic, or other

_____
Address

_____
City, State, Zip code

INFORMATION TO BE RELEASED:
_____ **Surgical Reports**
_____ **Progress Notes**
_____ **Lab Reports**

PURPOSE OF DISCLOSURE:

_____ **Changing Physicians**	_____ **Consultation/Second Opinion**	_____ **School**
_____ **Continuing Care**	_____ **Legal**	_____ **Insurance**
_____ **Workers Compensation**	_____ **Other (please specify):** _____	

1. I understand that this authorization will expire 90 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by sending notification to the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
3. I understand information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that I may refuse to sign this authorization.
5. I understand that my records may be sent by fax or mailed as a disc.
6. I understand that in compliance with Tennessee statute, I will pay a copying fee for my records: $20 for the first five pages and $.50 for every page over the initial five.
7. I understand that I may have a copy of this form after I sign it.

_____ OR _____
Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____
Witnessed **Date**