GALLAHER
PLASTIC SURGERY
& SPA MD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed in accordance to this may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Pt name: _____ DOB: _____

Address: _____ SS#: _____

City, State Zip: _____ Phone: _____

Persons/organizations **PROVIDING** the information:

___Tom Gallaher, MD
7560 Dannaher Drive, Suite 150
Powell, TN 37849

Phone: _____
Phone: (865)671-3888 Fax: (865)671-4911 Fax: _____

Persons/organizations **RECEIVING** the information:

_____ Tom Gallaher, MD
7560 Dannaher Drive Suite 150
Powell, TN 37849
Phone: _____
Phone: (865)671-3888 Fax: (865)671-4911 Fax: _____

Purpose of Disclosure:
□Changing Physicians □Legal □ 2nd Opinion/Consultation □ Insurance □Other:_____

Specific description of records requested including dates (H&P, progress notes, labs, x-rays,etc.):

_____

*I understand that I have a right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment 2.Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.
* I understand this form expires *ONE YEAR FROM SIGNING DATE*.
* I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.
* I understand that I may request a copy of this statement should I desire one.
* I understand that the healthcare provider requesting information will not receive financial compensation in exchange for using or disclosing the health information disclosed above.

Patient Signature _____ Date: _____ Chart#_____