Authorization to Release Medical Records/Information

Women's Health Specialists, PLLC

1800 Medical Center Parkway, Suite 350

Murfreesboro, TN 37129

Phone-(615-907-2040), Fax-(615-907-2827)

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed, because of this authorization, may be subject to disclosure by the recipient and will therefore no longer be protected by federal privacy regulations.

Patient Name_____________________________________ Patient Social Security #__________________________

Patient's Date of Birth______________________________ Patient Phone #_________________________________

Physician/Organization ***PROVIDING*** the information: Physician/Organization ***RECEIVING*** the information:

Women's Health Specialists ____

Physician/Organization telephone/fax number: Physician/Organization telephone/fax number:

(615) 907-2040 / Fax (615) 907-2827 ____

Information to be released includes date range: From: ____/____/____through____/____/____

□ Progress Notes □ Labs X All ObGyn Records Only □ Other_________________________________

Purpose of Use or Disclosure: **Changing Physician** Moving Second Surgical Opinion

Consultation Insurance Request

Other___________________________________

*I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

*I understand that this authorization will expire 12 months after the date listed below. I understand that I may cancel this authorization at any time by notifying the healthcare provider in writing. I understand that my cancelation will not affect any actions taken by the healthcare provider before receiving my cancelation.

*I understand that I may have a copy of this authorization.

*I understand I may be charged a fee if requesting records for personal use. . I understand that there may be a fee for records that are sent to another physician's office.

____ ____

Signature of Patient/Patient's Representative Date

Printed Name and relationship of Patient's Representative____