**TriState OBGYN**
**2900 Kirby Parkway Suite 11**
**Memphis. TN. 38119**
**Tel: (901) 345-4640**
**E-mail: contact@tristateobgynmd.com**

## AUTHORIZATION TO RELEASE MEDICAL RECORDS

| **Patient Name:** | |
|---|---|
| **Date of Birth:** | **Social Security#:** |
| Please list any other names you may have used: | |

**Please provide the following information: (Records cannot be sent if this information is incomplete).**

| Name: | Contact Name: | |
|---|---|---|
| Mailing Address: | | |
| City | State | Zip |
| Phone Number: | Fax Number: | |

**Purpose of the use or disclosure:**

| Patient Request | □ Change of Insurance □ Moving □ *Transferring Care to another Provider |
|---|---|
| *Please provide a brief reason for the transfer of care: | |
| | |
| Insurance Company Request | Purpose: □ Insurability □ Review for a claim □ Other specify: |
| Legal/Attorney | Purpose: |
| Other | Purpose: |
| | |

I authorize Cohen & Womack, MD, PC d/b/a Red Rocks Ob/Gyn the right to release the information specified below to the person, provider, organization or facility named on this request. I specifically authorize the release of information regarding the following condition(s):

| □ Drug abuse, if any | Initials: | □ Substance abuse, if any | Initials: |
|---|---|---|---|
| □ AIDS/HIV, if any | Initials: | □ Psychological or psychiatric conditions, if any | Initials: |

**Release these records:**

| □ Release only the records generated by this facility (not including records received from other sources) | Initials: |
|---|---|
| □ Release only some portion of the records maintained by this facility | Initials: |
| Specify the records to be released: | |
| | |
| □ Release all medical records at this facility | Initials: |

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**Attestation:** I understand that A) my health care and the payment for my health care will not be affected if I do not sign this form. B) I may see a copy of the information described on this form upon my request. C) A copy of this signed form is available to me.

**Expiration or revocation of authorization:**

This authorization will expire one year from the date signed below, unless I specifically revoke this authorization in writing. I may revoke this authorization at any time. I understand that once written revocation is received no further disclosure will take place until I sign a new authorization. **Use of copies:** A copy of this authorization may be utilized with the same effectiveness as the original.

| **Patient Signature:** | | Date: |
|---|---|---|
| **Person Authorized to Sign for Patient** | Relation to Patient: | |
| **Please Print Name:** | | |
| **Signature:** | | Date: |