Authorization for Release of Medical Information

Patient Name: ____

Date of Birth: ___________________ SS#: ____________________________

Address: _______________________ Telephone: ________________________

____

I hereby authorize (Dr/Office name): ____

PH: __________________________________ FAX: ______________________________

To release information to:

Tennessee GYN
9330 Parkwest Blvd, Ste 409
Knoxville, TN 37923

PH: **865-531-1173**
FAX : **865-531-8599**

FAX ONLY, DO NOT MAIL

For the following purpose: To improve care by review requested information

For treatment dates: __________________________

Type of access requested:

_____ Copies of the Record
_____ Inspection of the Record

_____ Physician/Clinic Office Notes
_____ Operative/Procedure Report
_____ Entire Record

_____ Lab
_____ Radiology
_____ Cardiac Studies/EKG

Other ____

______I acknowledge and hereby consent to such, that the released information may contain psychiatric, alcohol, drug abuse, HIV results, or AIDS information.

I understand that I may revoke this authorization at any time by notifying in writing the Medical Record Area of this physician practice. Such notice will not have any effect on any actions already made prior to this authorization. I understand that my health care, payment for my health care, enrollment or eligibility of benefits will not be affected if I do not sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy rules. This physician practice is released and discharged of any liability and the undersigned will hold the physician practice harmless for complying with "Authorization for Release of Medical Information".

__________ ______________________________________ ________________________

Date Signature of Patient/Parent/Conservator/Guardian Relationship to Patient

Fees/Charges will comply with all laws and regulations applicable to release of information