Authorization for Release of Medical Information

Patient Name: ____

Date of Birth: ____________________ SS#: ___________________________________

Address: _____________________________ Telephone: ______________________________

____

I hereby authorize: Tennessee GYN
9330 Parkwest Blvd, Ste 409 PH: 865-531-1173
Knoxville, TN 37923 FAX : **865-531-8599**

To release information to:

Dr/Office name: ____

PH: _____________________________________ FAX: ________________________________

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

For treatment dates: ____________________________

Type of access requested:

_____ Copies of the Record _____ Physician/Clinic Office Notes _____ Lab
_____ Inspection of the Record _____ Operative/Procedure Report _____ Radiology
_____ Entire Record _____ 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