Authorization for Exchange of Health Information

I hereby authorize the disclosure of the health information of the individual named below:

Patient Name: ____Date of Birth: ____________________

SSN:_________________________________

This information is to be disclosed **FROM** the following individual or organization:

DOCTOR:____
Address: ____
____ ____
PHONE______________________ FAX_____________________________

This information is to be disclosed **TO:**

DOCTOR:____
WOMEN Obstetrics & Gynecology, PLC
300 20th Avenue North Suite 505
Nashville, TN 37203
615-340-4596 (FAX)

The following information is authorized for use & disclosure:

- ❑ Office visit notes
- ❑ Lab test results
- ❑ Imaging test results
- ❑ Summaries of procedures, operations, hospitalizations
- ❑ Complete record
- ❑ Other (please specify) ______________________________

Reason for use & disclosure:

- ___ Continuing Care
- ___ Transfer of Care
- ___ Insurance
- ___ Personal reasons
- ___ Attorney/Court Case
- Other (specify) _________________________

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse. _________ (Initials)

Redisclosure: I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules. _________ (Initials)

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization. ________ (Initials)

Right to Inspect and Copy: I understand that I have a right to inspect and receive a copy of the information that is used or disclosed based on this authorization. ________ (Initials)

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If you do not specify an expiration date, event, or condition, this authorization will expire in six (6) months.)

Signature of Patient our Represenative:____

Patient's Name (printed) ____

Date: ____