Authorization to Disclose Health Information

Patient Name _____ Medical Record Number: _____

DOB _____ /_____ /_____ Social Security # _____ -_____ -_____ Phone # _____ -_____ -_____

1. I hereby authorize: **Women's Medical Associates**
2011 Murphy Avenue, Suite 601
Nashville, TN 37203
P: 615.329.6745 • F: 615.329.6785

OR

_____
_____
_____
Phone: _____ Fax: _____

to disclose the health information, as described below, of the above named patient to:

_____
_____
_____
_____

OR

Women's Medical Associates
2011 Murphy Avenue, Suite 601
Nashville, TN 37203
P: 615.329.6745 • F: 615.329.6785

2. **REASON FOR REQUEST**

☐ Second surgical opinion ☐ Changing Dr ☐ Consultation ☐ Other (Specify): _____
☐ Insurance request ☐ Disability ☐ Moving

3. **THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS:** *(include dates where appropriate)*

☐ Progress Notes ☐ Labs ☐ All ☐ Other (Specify): _____

Related to services provided during the following period of time: _____

Information to be excluded from this authorization: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. **INITIALS:** _____

4. **THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:**

A. I understand that this authorization will expire:
60 days from date of signing; or upon the happening of the following events: _____

B. I understand that I may revoke this authorization at any time. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.

C. I understand that authorizing the disclosure of this health information is voluntary, that I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.

D. I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Chemical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the redisclosure.

E. I understand that any disclosure of information carries with it the potential tor an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.

5. **RECORDS ARE ROUTINELY MAILED, PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP** (1 photo ID).

6. _____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Date

The authorization must be signed by the patient if 18 years of age or over or by a minor (under 18). If emancipated or otherwise eligible pursuant to KRS 214.185. or by the parent or legal guardian for any other minor of by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court Is needed us proof of executor or administrator and a written document is needed as proof of power-of-attorney.
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Women's Medical Associates of Nashville
AdvancedHEALTH

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