# Release of Medical and Billing Information

I, _____ , authorize Women's Medical Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name _____ Relationship _____

I, _____ , do not authorize anyone to have access to my billing and medical information.

Women's Medical Associates of Nashville may leave test results, instructions regarding medications or appointments at the following phone number(s), including an automated answering machine or voice mail.

Phone Number: ( _____ ) _____ - _____ Phone Number: ( _____ ) _____ - _____

**I understand that by signing this release, the designated person(s) above will be able to speak to any member of Women's Medical Associates of Nashville, PC staff. Furthermore, I understand that the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointment.**

_____ _____ /_____ /_____

Patient's Signature Date

_____ _____ /_____ /_____

Witness Signature Date

Women's Medical Associates of Nashville
AdvancedHEALTH

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