100 Covey Drive, Suite 205
Franklin, TN 37067

1. By signing this Authorization, I authorize Center for Pelvic Health to disclose protected health information to the following individual(s) for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures ar ein addition to those disclosures described in the Notice of Privacy Practices:

Name: ____ Relationship: ___________________________________
Method of Communication: ☐ Any ☐ Written Only ☐ In Person Only
Name: ____ Relationship: ___________________________________
Method of Communication: ☐ Any ☐ Written Only ☐ In Person Only

2. May we contact you regarding your protected health information, health status, appointments, and test results?

____ You may contact me by email, my address is ____
____ Do not contact me by email for this purpose.
____ Yes, you may contact me by phone, my daytime phone numbers are:
(_____)______________________________ (_____)______________________________
Can we leave a message regarding your protected health information at the numbers you provided above?
______ Yes _____ No

3. May we send you newsletters and other marketing information by email?

____ Yes, please use the following email address: ____
____ No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization in order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any redisclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address above. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: ____ Date: ___________________________
Printed Patient Name: ____ DOB: ___________________________
Signature of Patient Representative: ___________________________________ Date: ___________________________
Printed Name of Patient Representative: ______________________________ Relationship: _____________________