Center For Pelvic Health
100 Covey Drive, Ste 205
Franklin, TN 37067
Phone: 615-284-4664
Fax: 615-284-4668

Authorization for Release of Medical Records

Patient: _____ Date of Birth: _____
Social Security Number: _____ Phone #: _____

1. I authorize _____ (phone_____)
(fax_____) to release my health information to the Center for Pelvic Health.

2. The purpose for the use or disclosure is as follows: Continue Medical Care

3. The type and amount of information to be used or disclosed is as follows: health information covering treatment from: _____ to _____
Date of Service Date of Service

___Copy of Complete Record
___Abstract to include:
(H&P, Progress Notes, Procedure Reports, Consult
Discharge Summary, Diagnostic Testing, Dictations)
___History and Physical
___Consultation
___Discharge Summary
___Operative Procedure Report
___Pathology Report
___Laboratory Report
___X-Ray Report

4. I understand that my health information may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for drug and alcohol abuse.

5. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Practice. I understand that my revocation will not apply to the extent that CPH has taken in reliance on this authorization. I understand that my revocation will not apply if this authorization was obtained as a condition of obtaining insurance coverage and the law provides my insurer with the right to contest a claim under my policy or the policy itself. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. CPH may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that if I authorize CPH to disclose my health information, the health information may be subject to re-disclosure by the recipient and may no longer be protected by certain federal privacy regulations.

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date