WOMEN'S HEALTH ASSOCIATES

200 New York Avenue, Suite 150
Oak Ridge, TN 37830
Phone # 865-481-0200
Fax # 865-481-3085

9330 Parkwest Blvd., Suite 300
Knoxville, TN 37923
Phone # 865-531-1400
Fax # 865-690-9750

Authorization to Release Medical Records/Information

Facility to provide records: Women's Health Associates

Patient's Name:______________________________

Social Security Number:______________________DOB:______________

Person/Facility to receive records:______________________________

Address:______________________________

City, State, Zip:______________________________

Telephone Number:____________________Fax number:____________

Release these records: **(Choose 1, 2, or 3 – Not all)** Initials

1. Only records generated by this facility (not including records received from other sources)…._______
2. Only some portion of records maintained at facility (dates of treatment, etc., specify below)…_______
   Specify the records you need______________________________
3. All medical records at this facility………………………………………………………………………_______

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND INITIAL THE BOXES FOR INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR RECORDS WILL BE RELEASED AS SPECIFIED ABOVE.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of:

Initials	Initials
________ Substance abuse, if any	_______ AIDS/HIV, if any
________ Psychological or psychiatric conditions, if any	

Other (Please specify)______________________________

Expiration or revocation of authorization – I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Use of copies – A copy of this authorization may be utilized with the same effectiveness as an original.

Patient name:

____
Print or type name

____
Patient's signature

____
Date

Person authorized to sign for patient:

____
Print or type name

____
Signature

____
Relationship to patient

____
Date

Revised 1-23-04