

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

Physician or facility to provide records to Women's Health Associates:

Please include address and phone number: _____

Patient's Name: _____

Social Security Number: _____ DOB: _____

- 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....._____
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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:

<u>Initials</u> _____ Substance abuse, if any	<u>Initials</u> _____ 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: _____

Person authorized to sign for patient: _____

Print or type name

Print or type name

Patient's signature

Signature

Relationship to patient

Date

Date