Authorization to Disclose Health Information

Women's Medical Associates
2201 Murphy Avenue, Suite 110
Nashville, TN 37203

Patient Name: _____ Medical Record Number: _____

Date of Birth: _____ Social Security #: _____-___-_____ Phone #: _____

1. I hereby authorize Women's Medical Associates or _____
   2201 Murphy Ave, Suite 110 _____
   Nashville, TN 37203 _____
   Phone (615) 329-6745 Phone _____
   Fax (615) 329-6785 Fax _____

   to disclose the health information, as described below, of the above named patient to:

   _____ or Women's Medical Associates
   _____ 2201 Murphy Ave, Suite 110
   _____ Nashville, TN 37203
   _____ Phone (615) 329-6745
   _____ Fax (615) 329-6785

2. **REASON FOR REQUEST**

   _____ Second surgical opinion
   _____ Insurance request
   _____ Changing Dr.
   _____ Disability
   _____ Consultation
   _____ Moving
   _____ Other (Specify) _____

3. **THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS:**
   (include dates where appropriate)

   _____ Progress Notes
   _____ All
   _____ Labs
   _____ Other (Specify) _____

   Related to services provided during the following period of time: _____

   Information to be excluded from this authorization: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials: _____

4. **THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:**

   A. I understand that this authorization will expire: 60 days from date of signing; or
      upon the happening of the following events:
      _____

   B. I understand that I may revoke this authorization at any time. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.
   C. I understand that authorizing the disclosure of this health information is voluntary, that I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.
   D. I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Chemical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the redisclosure.
   E. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.

5. **RECORDS ARE ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP. (1 photo ID)**

6. _____ _____
   Signature of Patient or Legal Representative **Date**

   _____ _____
   If Signed by Legal Representative, Relationship of Patient **Signature of Witness**

The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18). If emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor of by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney.