Release of Medical and Billing Information

I, ____ , authorize Women's Medical Associates and their staff to release information on file regarding my medical treatment, billing information and appointment information to the person(s) listed below:

Name ____ Relationship __________________________

I, ____ , do not authorize anyone to have access to my billing and medical information.

Women's Medical Associates of Nashville may leave test results, instructions regarding medications or appointments at the following phone number(s), including an automated answering machine or voice mail.

Phone Number: (_______) _________ - ____________ Phone Number: (_______) _________ - ____________

I understand that by signing this release, the designated person(s) above will be able to speak to any member of Women's Medical Associates of Nashville, PC staff. Furthermore, I understand that the physician's office cannot be held liable for any information the above stated person(s) may obtain regarding my medical care or my account and/or appointment.

____ _______ /_______ /_______

Patient's Signature Date

____ _______ /_______ /_______

Witness Signature Date

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