WOMEN'S CARE GROUP

Maryville Office
Authorization for Release of Protected Health Information

Patient Name: _____ Chart Number: _____

Address: _____ Date of Birth: _____

_____ SS Number: _____

Patient Insurance: _____ Phone Number: _____

Please fill out completely to insure accurate and prompt receipt of records

Purpose of release:

- ❑ Continuing medical Care
- ❑ Release to patient
- ❑ Insurance coverage
- ❑ Insurance reimbursement

I authorize my protected health information to be:

Released to: _____

Address/Phone/ Fax: _____

Obtained from: _____

Address/Phone/Fax: _____

Please specify information to be released/obtained:

- ❑ Complete Record
- ❑ Last Visit
- ❑ OB Records
- ❑ Labs
- ❑ Mammogram
- ❑ Op Notes
- ❑ H&P
- ❑ HIV/STD Test(s)
- ❑ Pap/Biopsy
- ❑ Consult

Statement of Time Limitations

I understand that this authorization is valid for ninety (90) days from the date of signature below. If a long/shorter period of time is desired please specify the desired time frame in the spaces below:

_____ To_____

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released. I understand that my medical record may contain information from other health care providers, which has been filed with my medical records.

_____ _____

Patient Signature *Date*

_____ _____

Witness Signature *Date*

Upon completion fax this form to: Maryville Medical Records Office @ 865-681-7949

If you have any questions of need assistance call Maryville Medical records @ 865-984-9017