330 23rd Ave. N, Suite 604
Nashville, TN 37203
Phone (615) 986-6039
Fax (615) 234-1520

PATIENT REQUEST FOR MEDICAL RECORDS

DATE: _______________________________ **(All sections must be completed)**

Patient Name: ____ Date of Birth: ______________________________

I hereby authorize: Tennessee Women's Care ____________ and its physicians employees and agents to release or disclose to the below-named recipient all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection. I hereby authorize the release of medical records to:

Provider: Advanced Women's Health of Nashville
Address: 330 23rd Ave N, Suite 604, Nashville, TN 37203
Phone: 615-986-6039 Fax: 615-234-1520

Purpose of disclosure: (x) Changing provider ( ) Moving out of town ( ) Other: ___________________________________

The authorization will expire on: ____
Date or Event may not exceed one year

This request and authorization applies to:

___x___ All medical records, including any third party records contained within my chart.

_______ Health care information relating to the following treatment, condition, or dates of treatment:
____

_______ Specific records to be released (eg. Labs, imaging reports, other):
____

If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.

______Substance abuse ______ Psychological or psychiatric treatment ____HIV/AIDS/STD

Form and format of information: (x) Fax to 615-234-1520

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

____

Signature of Patient or Authorized Representative Date Signed Relationship to Patient