



Women's Group of Franklin

4323 Carothers Parkway, Suite 208 • Franklin, TN 37067 • 615 778-0010 • Fax 615 778-0715

Release of Information Authorization

I hereby authorize the use or disclosure of my health information as described below.

Patient Name: _____

Patient Date of Birth: _____

Physician/Organization providing the information:

Physician/Organization receiving the information:

Information to be released includes date range: From ____/____/____ through ____/____/____

☐ All records ☐ Progress notes ☐ Labs ☐ Other: _____

Purpose of use or disclosure: ☐ Changing Physician ☐ Moving ☐ Second Surgical Opinion
☐ Consultation ☐ Insurance Request
☐ Other: _____

*I understand that if the person or entity receiving my health information from Women's Group of Franklin is not a health plan or health care provider covered by federal privacy regulation, the health information may be redisclosed by the recipient and may no longer be protected by federal or state law.

*I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits.

*I understand that this authorization will expire 30 days after dated listed below. I understand that I may cancel this authorization at any time by notifying the healthcare provider in writing. I understand that my cancellation will not affect any actions taken by the healthcare provider before receiving my cancellation.

*I understand that I may have a copy of this authorization.

Signature of patient or patient's representative

Date

Printed name and relationship of patient's representative: _____