WOMENS GROUP OF FRANKLIN, PLLC

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RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed because of this authorization may be subject to redisclosure by the recipient and will therefore no longer be protected by federal privacy regulations.

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 is not a health plan or health care provider covered by federal privacy regulation, the health information may be re-disclosed 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: _____