Women's Healthcare of Morristown
1621 W. Morris Blvd.
Morristown, TN 37813
PHONE: 423-492-7100 FAX: 865-331-1976

If any section is **INCOMPLETE,** this form may be **invalid.** You may be ***charged for copies*** in association with state law.

I, _____, hereby authorize _____(the "Provider")
to **disclose** health information regarding the following **patient (**provide previous names used):

Patient Name:_____ Social Security No: _____
Address:_____ Date of Birth: _____/_____/_____
City/State:_____Zip:_____ Phone:_____ EDD*:_____

[ ] 1. RELEASE Information TO: **OR** **[ ] 2. OBTAIN** Information FROM:

Provider & Clinic Name OR Individual Contact:

_____
Attention:_____
Address: _____
City/State:_____
Ph: _____ **Fax:** _____

FROM: Women's Healthcare of Morristown
PH: 423-492-7100 FAX: 865-331-1976
1621 W. Morris Blvd., Morristown, TN 37813

Full Hospital Name OR Provider & Clinic Name:

_____
_____
Address: _____
City/State: _____
Ph: _____ **Fax:** _____

TO: Women's Healthcare of Morristown
PH: 423-492-7100 FAX: 865-331-1976
1621 W. Morris Blvd., Morristown, TN 37813

Purpose of Release:

[ ] Continue Care for both providers [ ] Transfer of Care to _____
[ ] At the request of the Patient [ ] Other: _____

Information to be Disclosed: The information to be disclosed includes only those items checked below.

[ ] Entire Medical Records [ ] Last PAP and OB/GYN Notes on or around:_____
[ ] OP reports on or around: _____ [ ] Lab and Ultrasound Reports on or around:_____
[ ] Other: _____

I request that you send the following: [ ] AIDS/HIV Status _____ [ ] Mental Health Records _____
[ ] Substance Abuse *(if any)*____ [ ] Other: _____

*I understand that I may **revoke** this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received. I understand that unless I revoke the authorization earlier this authorization will **expire one year after the date** of this authorization is signed or by the specified expiration date or event noted below. I understand that I may **refuse to sign** this Authorization and the the Provider will not condition treatment on whether I sign this Authorization. Once this information is disclosed it may be subject to **redisclosure** and may no longer be protected.*

I certify that I am (check whichever applies):

[ ] the patient, and the identification that I have provided is true and correct
[ ] the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: [ ] Parent [ ] Gaurdian [ ] Other: _____

Signature: _____ Date: _____

Print Name: _____ Expiration Event/Date: _____

ONE COPY TO BE RETAINED BY THE PATIENT

*OPTIONAL: Expected Delivery Date for pregnancy

For Provider Use Only:

Date Received: _____ Charges: _____ Paid on:_____

How was Identity Verified: _____ Copy made: [ ] Yes [ ] No

How was Authority Verified: _____Copy made: [ ] Yes [ ]No

BY:_____Title:_____

STAFF:

1. Allow/Advise patient to complete this form completely. We can not ADD or DELETE information later.
2. Verify identity with a picture ID. Can utilize the EMR PHOTO for existing patients that have provided ID at registration.
3. Verify authority for ***MINORS with GUARDIANS*** with a legal document.
4. Note who is verifying identity with name and title; (i.e. *Jane Doe, MA*, *John Law, Patient Account Rep)*
5. Provide a copy of this release to patient.
6. Expiration events can be final resolution of specific events, litigation, post partum visit, etc.
7. Provide one form per request. (i.e. obtain and release requests need seperate forms completed, hospital and provider/clinic need a separate request.

NOTE: Hospital, Surgery and Delivery Notes must be requested from the facility whre procedure was preformed. Do NOT request these records from the Physician/Provider that performed the procedure.