ADVANCED
WOMEN'S HEALTH OF NASHVILLE
OBSTETRICS • GYNECOLOGY • INFERTILITY

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:_____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: _____

Address: _____

Phone: _____ Fax: _____

Purpose of disclosure: _____

_____

The authorization will expire on: _____

Date or Event may not exceed one year; or will expire in one year from execution

This request and authorization applies to:

_____ 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

Release can be emailed to: appointments@womenshealthnashville.com or faxed 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