**Patient Election Form and Authorization**

**Record Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Whom it May Concern:

I have been a patient of Dr. Kim Scott. Effective January 1, 2019 (**select one**):

**\_\_\_\_\_\_** I wish to remain a patient of The Women’s Group of Franklin, PLC

**\_\_\_\_\_\_**  I wish to remain a patient of Dr. Scott at her new location

If I have chosen to remain a patient of Dr. Scott, I hereby authorize and direct The Women’s Group of Franklin, PLC, to make a copy of my entire medical record available to Dr. Scott, as soon as is possible.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed** name of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Please return this form to The Women’s Group of Franklin, PLC,** **in the enclosed envelope once you have completed it.**