**WOMENS GROUP OF FRANKLIN, PLLC**

**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. 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:**