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OBSTETRICS AND GYNECOLOGY
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(615)-341-0991
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MEDICAL RECORDS RELEASE

Patient's Name_____
DOB _____
SSN _____
Patient's Address _____
_____

I authorize my records to be released to

Phone # _____
Fax # _____

For the purpose of_____

Treatment Dates or Specifics needed_____
_____

I, the undersigned, have read the above and authorize the staff of Dr. Carolyn Thompson to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge, and hereby consent to such, that the released information may contain HIV testing, HIV results, AIDS, psychiatric, STD's and or substance abuse information. I also understand that any disclosure is bound by Title 42 of the Code Of Federal Regulations governing the confidentially of alcohol and drug abuse patient records ad that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless, or complying with the "Medical Records Release". This authorization expired 60 days from the date below, and covers only treatment periods indicated above.

_____ _____
_____
DATE **Patient or Legal Guardian** **Relationship**

NOTICE **to person or agency receiving information: Federal laws & regulations prohibit redisclosure of the information whose confidentiality is protected in the absence of specific consent of the patient or person authorized to consent for treatment.**