Complete Women's Care
2020 Rocksprings Road Smyrna, TN 37167
Phone: 615.223.0200 Fax: 615.223.8704 Email: admin@cwcobgyn.net

Patient: _____

DOB: ____/____/_____ **SSN:** _____ **Phone:** _____

Address: _____

Release medical records (circle) to or from: Circle the provider:

Kimberly King, M.D. **Mistye Taylor, M.D.** **George Fox, M.D.** **Alixandra Hunzicker, M.D.**

Request medical records (circle) to or from: Provider name/Office name: _____

Address:_____

Phone: _____

Fax: _____

Specific type of information to be released: [ ] Any/all records [ ] Diagnostic Reports [ ] Lab Results

[ ] Chart Notes [ ] Consultation Notes [ ] Operative Notes [ ] Other_____

For date range: _____to_____

*if no time period specified, records from previous 5 years only will be released

Purpose of disclosure: [ ] Transfer of care [ ] Pcp to Gyn [ ] Other

I understand that my medical records may contain information related to communicable disease and infection information as defined by statute and Tennessee Department of Public Health Rules (which included venereal disease "VD", tuberculosis "TB", Hepatitis (any form), Human Immunodeficiency virus "HIV", Acquired Immunodeficiency Syndrome "AIDS", and AIDS Related Complex "ARC") Alcohol and/or drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, part 2; and Mental Health treatment records, Psychological services and/or Social Services information including communications made to or by a social worker, psychologist or psychiatrist. I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revokes, this authorization will expire after one (1) year. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it potential for any unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. If I have any questions about disclosure of my health information, I can contact the Privacy Officer and the disclosure location.

X _____

Signature of patient

X _____

Sign here if signed by Legal Representative,

List the relationship to patient: _____

Today's Date: ___/_____/_____**Complete Women's Care office contact:** _____