Authorization to Release PHI/Medical Records to:
Obstetrics & Gynecology of Hixson, PLLC Fax: (423) 702-9245

I hereby authorize any physician or person who has attended and examined me to release for purposes of treatment my entire medical record (pursuant to state and federal law), including without limitation, any and all information with respect to any illness, injury, medical history, and/or medical records pertaining to:

Patient Name:_____

Patient's Date of Birth: _____

PROVIDER/FACILITY RELEASING RECORDS:

THEIR ADDRESS: _____

FAX NUMBER: _____ PHONE NUMBER: _____

I understand that information in my health record may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care and treatment related to drug or alcohol use: my signature authorized the release of such information.

This authorization expires within 90 days from the date below, unless I revoke this authorization earlier. I understand that I may revoke this authorization at any time, except to the extent that actions based on this authorization have already been taken. Our Notice of privacy Practices explains the process of revocation, which includes a request in writing.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I understand that if any of the information released relates to the treatment for alcohol or drug abuse, there are special requirements for my consent to release as found in Federal Confidentiality Rules (42 CFR Part 2) which prohibit the further release of that information without my consent, referenced in the federal regulations, or as otherwise permitted by law.

I understand that the provider releasing the PHI/medical record to Obstetrics & Gynecology of Hixson, PLLC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at releasing provider may or may not protect this information once it has been disclosed to the recipient.

Printed Name of Patient:_____

Date: _____

Signature of Patient: _____

This patient's record is released for the sole purpose revealed above. Any further release of information, review, dissemination, distribution, or copying of this information is strictly prohibited. **If you receive this message in error, please notify us immediately by phone at (423) 702-9240.**