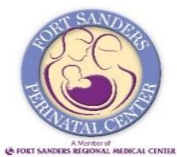
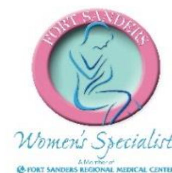


Fort Sanders Perinatal Center and Women's Specialists

501 19th Street, Suite 401 in Trustee Tower, Knoxville, TN 37916
PHONE: 865-331-1975 or 865-331-2020 FAX: 865-331-1976



If any section is **INCOMPLETE,** this form may be **invalid.** You may be ***charged for copies*** in association with state law.

I, ____, hereby authorize ________________________(the "Provider")
to **disclose** health information regarding the following **patient** (provide previous names used):

Patient Name:____ Social Security No: _____________________
Address:____ Date of Birth: ______/_____/______
City/State:___________________________Zip:______ Phone:________________ EDD*:____________________

[ ] 1. RELEASE Information **TO:**	OR	**[ ] 2. OBTAIN** Information **FROM:**
Provider & Clinic Name OR Individual Contact:		**Full Hospital Name OR Provider & Clinic Name:**
____		____ ____
Attention:_____________________________________		
Address: ____________________________________		**Address:** ____________________________________
City/State:__________________________________		**City/State:** __________________________________
Ph: _________________ **Fax:** _______________		**Ph:** _________________ **Fax:** ________________
FROM: Fort Sanders Perinatal Center and **Fort Sanders Women's Specialists** PH: 865-331-1975 FAX: 865-331-1976 501 19th Street, Suite 401, Knoxville, TN 37916		**TO: Fort Sanders Perinatal Center and** **Fort Sanders Women's Specialists** PH: 865-331-1975 FAX: 865-331-1976 501 19th Street, Suite 401, Knoxville, TN 37916

Purpose of Release:

[ ] Continue Care for both providers [ ] Transfer of Care to _______________________________________
[ ] At the request of the Patient [ ] Other: ____

Information to be Disclosed: The information to be disclosed includes onlv those items checked below.

[ ] Entire Medical Records [ ] Last PAP and OB/GYN Notes on or around:___________
[ ] OP reports on or around: _________________ [ ] Lab and Ultrasound Reports on or around:___________
[ ] Other: ____

I request that you send the following: [ ] AIDS/HIV Status _____ [ ] Mental Health Records _____
[ ] Substance Abuse *(if any)*____ [ ] Other: ____

*I understand that I may **revoke** this authorization at any time by sending a written notice to the Provider. However, the revocation will not have any effect on any uses or disclosures the Provider may have made before the revocation was received. I understand that unless I revoke the authorization earlier this authorization will **expire one year after the date** of this authorization is signed or by the specified expiration date or event noted below. I understand that I may **refuse to sign** this Authorization and the the Provider will not condition treatment on whether I sign this Authorization. Once this information is disclosed it may be subject to **redisclosure** and may no longer be protected.*

I certify that I am (check whichever applies):

[ ] the patient, and the identification that I have provided is true and correct
[ ] the patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: [ ] Parent [ ] Gaurdian [ ] Other: ________________

Signature: ____ Date: ____________________________

Print Name: ____ Expiration Event/Date: ______________

ONE COPY TO BE RETAINED BY THE PATIENT

*OPTIONAL: Expected Delivery Date for pregnancy

For Provider Use Only:

Date Received: ______________________________ Charges: _____________ Paid on:_______________

How was Identity Verified: ____ Copy made: [ ] Yes [ ] No

How was Authority Verified: ____Copy made: [ ] Yes [ ]No

BY:____Title:___________________________

STAFF:

1. Allow/Advise patient to complete this form completely. We can not ADD or DELETE information later.
2. Verify identity with a picture ID. Can utilize the EMR PHOTO for existing patients that have provided ID at registration.
3. Verify authority for ***MINORS with GUARDIANS*** with a legal document.
4. Note who is verifying identity with name and title; (i.e. *Jane Doe, MA*, *John Law, Patient Account Rep)*
5. Provide a copy of this release to patient.
6. Expiration events can be final resolution of specific events, litigation, post partum visit, etc.
7. Provide one form per request. (i.e. obtain and release requests need seperate forms completed, hospital and provider/clinic need a separate request.

NOTE: Hospital, Surgery and Delivery Notes must be requested from the facility where procedure was preformed***. Do not*** request these records from the Physician/Provider that performed the procedure.