GALLATIN WOMEN'S CENTER, PC

*AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS*

Date: _____

Patient Name: _____ Date of Birth: _____

I authorize the following Medical Office to release Personal Health Information for the patient named above to Gallatin Women's Center.

Records coming from:

Name_____

Address_____

City_____State_____Zip_____

Phone_____Fax_____

Records being sent to:

Gallatin Women's Center
437 East Main Street
Gallatin, TN 37066
Phone: 615-452-8705 Fax: 615-452-8740

This release includes specifically (circle all that apply):

| | | |
|---|---|---|
| Complete Records | Office Notes | Laboratory Reports |
| Prenatal/Obstetrical | Radiology/Imaging Reports | Operative/Pathology |
| History and Physical | EKG | |

I acknowledge and hereby consent to such that the release of information may contain information regarding alcohol, drug abuse, psychiatric, HIV testing, AIDS or other sensitive information. I understand that I may revoke this authorization at any time, in writing and I may also request a copy of the information for a reasonable copy fee.

Patient Signature or Guarantor if patient is under 18 years of age.

_____ _____

Signature Date

_____ _____

Printed Name Relationship to Patient