



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: Gallatin Women's Center
437 East Main Street
Gallatin, TN 37066
Phone: 615-452-8705 Fax: 615-452-8740
Email: staff@gallatinwomenscenter.com

Records being sent to: Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____

This release includes specifically (circle all that apply):

Complete Records
Prenatal/Obstetrical
History and Physical

Office Notes
Radiology/Imaging Reports
EKG

Laboratory Reports
Operative/Pathology

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