Women's HEALTH CENTER OF CLARKSVILLE

2292 Dalton Drive, Suite C
Clarksville, TN 37043
Phone: 931-645-5595
Fax: 931-645-5596

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

REQUEST RECORDS FROM:

Person or facility releasing your records: _____

Phone / Fax (please circle which): _____

I hereby authorize the disclosure of the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed by this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting this confidentiality.

Patient Name (print): _____

Date of birth (mm/dd/yyyy): _____-_____-_____ Social Security #: _____-_____-_____

Address: _____

Street City State Zip code

SEND RECORDS TO:

Name/Facility: Women's Health Center of Clarksville

Address: 2292 Dalton Drive, Suite C. Clarksville, TN 37043

Phone / Fax: 931-645-5595 931-645-5596

Please disclose the following information:

Current prenatal record to include: 1st ultrasound confirming viable pregnancy, prenatal labs, PAP smear, Gonorrhea/Chlamydia, RPR (syphilis), Hepatitis B surface antigen, HIV 1-2, sickle-cell, down syndrome screening, 1hr/3hr glucose test, CBC w/ PLT & differential, Group B strep, & any ultrasounds during current pregnancy.

Previous C-section reports

I direct that all information obtained with this release be held in strict confidence by the recipient and further direct that it is not to be further disclosed without my specific written authorization. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space: _____. I understand that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved. I am also releasing information specified above containing treatment for drug and/or alcohol abuse, for psychiatric and/or mental conditions, or HIV test results (if applicable) or diagnosis. I am including this type of information to be release in association with this authorization.

Patient Signature: _____ Date: _____

(For Office Use) Witness: _____ Date: _____