OBSTETRICS GYNECOLOGY

LE CONTE
WOMEN'S HEALTHCARE
ASSOCIATES, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____(DOB _____SSN_____) understand that LeConte Women's Healthcare ("LWH") is authorized by me to use or disclose my Protected Health Information for a purpose (described in this document) other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditioned upon me signing this authorization. I specifically authorize LWH or its designated employee(s) to disclose my Protected Health Information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations. I further understand that I retain the right to revoke this authorization, if done according to the steps set forth below.

1. Description of the information to be used or disclosed (check as appropriate):

☐ **a. My entire record:**
I understand that checking the box for "my entire record" authorizes the use or disclosure of all information in my medical record including, but not limited to: demographic info, medical histories, medication lists, tests, and diagnoses. I understand that my medical record may contain sensitive information. I specifically authorize the use or disclosure of any information in my medical record related to **(check all that apply)**:

- ☐ Alcohol and Drug Abuse Treatment*
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS)
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment
- ☐ Genetic Information (including, but not limited to, Genetic Test Results).

(NOTE: If you checked "MY ENTIRE RECORD," please SKIP to number 2. Otherwise, please continue with b. and c. below.)

☐ **b. My demographic information (check "All" or those that apply):**

☐ All ☐ Age ☐ Gender ☐ Race ☐ Other_____
☐ Name ☐ Address ☐ State/Zip Code Only ☐ Telephone

☐ **c. Medical Data/Information as related to (check all that apply):**

- ☐ Specific condition(s):_____
- ☐ Specific professional service(s):_____
- ☐ Specific medication(s):_____
- ☐ Alcohol and Drug Abuse Treatment:*
- ☐ Mental and Behavioral Health (other than psychotherapy notes) and Developmental Disability Treatment:_____
- ☐ HIV/Acquired Immune Deficiency Syndrome (AIDS):_____
- ☐ Genetic Information including, but not limited to, Genetic Test Results:
- ☐ Other: _____

2. Please disclose the above information to:

Name/Entity:_____

Address:_____

Telephone:_____Fax:_____

3. I ☐ do ☐ do not authorize this information to be disclosed electronically.

4. Purpose(s) for disclosure of the information:_____

5. This authorization shall expire on _____. (Date may not exceed one year). After this date/event, LWH can no longer use or disclose my Protected Health Information for the above purposes without first obtaining a new authorization form.

6. Right to revocation. I have a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization. In order for the revocation of this authorization to be effective, LWH must receive the revocation in writing, and the revocation must include: My name and address, the effective date of this authorization, and the recipients of the Protected Health Information according to this authorization, my desire to revoke this authorization, and the date of the revocation, and my signature. LWH will accept written revocations of this authorization via: Facsimile (865) 908-8756. ALL revocations must be sent to the Practice Administrator, and are not effective until received by him/her.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Name of Patient or Representative

_____
Description of Representative's authority to act for patient

OFFICE USE ONLY:

_____
Name of Facility Requesting Records From

_____
Phone number Fax number

740 MIDDLE CREEK RD – SUITE 200 ■ SEVIERVILLE, TN 37862
865.908.9888 ■ FAX 865-908-8756