



# State of Franklin OB/GYN Specialists

A division of State of Franklin Healthcare

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Johnson City, TN 37604

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## AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_  
DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_ Telephone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

I give my permission for **State of Franklin OB/GYN Specialists** to  
Please circle one ⇒ **RECEIVE / PROVIDE (SEND)**  
my medical records as indicated below.

Facility/person to receive or provide records: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_ Fax: \_\_\_\_\_

RECORDS REQUESTED: \_\_\_\_\_ Last 10 Years of Record \_\_\_\_\_ Lab Results \_\_\_\_\_ Office Notes  
\_\_\_\_\_ Last 3 Years of Record \_\_\_\_\_ Radiology Reports \_\_\_\_\_ Pap Smear  
\_\_\_\_\_ Operative Notes \_\_\_\_\_ Other – \_\_\_\_\_  
\*\*DATES OF RECORDS REQUESTED: \_\_\_\_\_

PURPOSE REQUESTED: \_\_\_\_\_ Personal Use \_\_\_\_\_ Transfer of Care \_\_\_\_\_ Dr. to review  
\_\_\_\_\_ Insurance Purposes \_\_\_\_\_ Other (Must Specify) \_\_\_\_\_

I understand that this WILL INCLUDE information relating to: Acquired Immunodeficiency Syndrome (AIDS), Human immunodeficiency virus (HIV) infection, Behavioral health service / psychiatric care, and treatment for alcohol and/or drug abuse.  
If applicable, the following information SHOULD NOT BE DISCLOSED: \_\_\_\_\_

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. To revoke the authorization, I understand I must contact the following in writing: State of Franklin Healthcare Associates, Attn: Privacy Officer, 2428 Wesley St. Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire on the following date, event, condition or within one year from the time I signed this form: \_\_\_\_\_  
The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware that information will not be released to a non-custodial parent unless we have a court order stating otherwise.

\_\_\_\_\_  
Patient Name (print)  
\_\_\_\_\_  
Patient's Signature  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Person authorized to sign of patient (print)  
\_\_\_\_\_  
Signature / Relationship to patient  
\_\_\_\_\_  
Date

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