ARIZONS
OBSTETRICS & GYNECOLOGY

MEDICAL RECORDS RELEASE FORM

PHYSICIAN_____

ADDRESS_____

PHONE_____FAX_____

PLEASE SEND MY RECORDS TO:

Arizons Obstetrics & Gynecology

820 N. Thompson Lane Suite 1-A

Murfreesboro, TN 37129

Phone (615) 494-4800 / Fax (615) 494-4801

PLEASE FORWARD ONLY THE INFORMATION I HAVE CHECKED

☐ ALL RECORDS ☐ LAST PAP ☐ LABS ONLY ☐ X-RAYS ONLY

PLEASE DO NOT FORWARD TREATMENT INFORMATION REGARDING ANY OF THE CONDITIONS I HAVE CHECKED.

☐ SUBSTANCE ABUSE ☐ PSYCHOLOGICAL OR PSYCHIATRIC CONDITIONS ☐ AIDS/HIV ☐ OTHER_____

THE PURPOSE OF THIS REQUEST IS "AT THE REQUEST OF THE PATIENT" UNLESS OTHERWISE STATED.

I UNDERSTAND THAT IF I DO NOT CONSENT TO HAVING PREVIOUS MEDICAL RECORDS DISCLOSED, I WILL NOT BE DENIED TREATMENT. I FURTHER UNDERSTAND THAT WHEN MY INFORMATION IS USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION, IT MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY THE FEDERAL HIPAA PRIVACY RULE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZTION IN WRITING EXCEPT TO THE EXTENT THAT THE PRACTICE HAS ACTED IN RELIANCE UPON THIS AUTHORIZTION. MY WRITTEN REVOCATION MUST BE SUBMITTED TO THE PRIVACY OFFICER AT THE ABOVE LOCATION. THIS AUTHORIZATION WILL EXPIRE IN 90 DAYS.

PATIENT NAME_____ DATE_____

DATE OF BIRTH_____ SS #_____

PATIENT OR LEGAL GUARDIAN SIGNATURE_____