Associates in Women's Health

Matthew A. Roberts, D.O. • Terry L. Williams Jr., D.O. • Mary Helen Durland, FNP • Tessa Eckhardt, FNP • Heidi Septor, FNP • Hannah White, FNP

(check one)

_____ **Releasing** information from us to you or your provider

_____ **Requesting** information from another provider to us

Date: _____ Patients Name: _____

DOB: _____ Social Security Number: _____ - _____ - _____

I authorize Associates in Womens Health to (circle one) release / request the following:

_____ All Medical Records

_____ Other Please specify: _____

Purpose of Request: _____

To / From:

Name: _____

Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

I do not have to sign this authorization in order to receive treatment from Associates in Womens Health. In fact, I have the right to refuse to sign this authorization. When my 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 the federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Office Manager at: 93 Robin Rd. Ringgold, GA 30736.

Patient Signature: _____ Date: _____

Witnessed by: _____ Date: _____