

10031 Sherrill Blvd | Knoxville | TN 37932 | p: 865.540.1650 | f: 865.246.4754

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_  
**(FIRST) (MIDDLE) (LAST)**

**PLEASE OBTAIN INFORMATION FROM**

**PLEASE SEND INFORMATION TO**

\_\_\_\_\_  
**Name of Provider/Clinic/Organization**

\_\_\_\_\_  
**Name of Provider/Clinic/Organization**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**Street Address**

\_\_\_\_\_  
**City, State and Zip**

\_\_\_\_\_  
**City, State and Zip**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Fax**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Fax**

**I AUTHORIZE THE FOLLOWING INFO TO BE RELEASED: (PLEASE INITIAL)**

\_\_\_\_\_ ALL Medical Records maintained at this facility

\_\_\_\_\_ Other (please specify) \_\_\_\_\_

**IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORD RELEASED, PLEASE INITIAL BELOW THE RECORDS THAT ARE NOT TO BE RELEASED:**

\_\_\_\_\_ Substance Abuse, if any \_\_\_\_\_ Psychological or psychiatric conditions, if any

\_\_\_\_\_ AIDS/HIV, if any \_\_\_\_\_ Other \_\_\_\_\_

**PURPOSE OF RELEASE: (PLEASE INITIAL)**

\_\_\_\_\_ At My Request \_\_\_\_\_ Legal/Attorney \_\_\_\_\_ Insurance

\_\_\_\_\_ Continuing Care \_\_\_\_\_ Social Security

\_\_\_\_\_ Other \_\_\_\_\_

- ✓ I understand that I may revoke this authorization, in writing, at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. \*To withdraw sign below
- ✓ I understand that I do not have to sign this authorization to get treatment.
- ✓ I understand that once my health care information is disclosed as I have authorized it could be re disclosed by the recipients as I direct. Contemporary Women's Health, PLLC is not responsible for any subsequent release of this information that is not in compliance with federal confidentiality rules.
- ✓ I understand that signing this authorization does not cancel any rights I have under other state and federal laws.
- ✓ A copy of this authorization may be utilized with the same effectiveness as an original.

\_\_\_\_\_ Date \_\_\_\_\_

**Patient Signature to RELEASE INFORMATION**

FAX RECORDS  MAIL RECORDS  PICK-UP RECORDS

I wish to withdraw this authorization \_\_\_\_\_ Date \_\_\_\_\_

**COPAYS FOR MEDICAL SERVICES ARE DUE AT TIME OF SERVICE.**

**PLEASE BRING YOUR INSURANCE CARD TO EVERY VISIT.**

Thank you for choosing Contemporary Women's Health!  
Kimberly Roberts, MD, F.A.C.O.G.    Ceecy Yang, MD, F.A.C.O.G.    Jennifer Brantley, MD  
Donna Dossett, WHNP-C    Brynn Whitworth, WHNP-C  
Autumn Galbraith, WHNP-C    Marissa Turner, PA-C