

TENNESSEE FERTILITY Institute

9160 Carothers Pkwy, # 201
Franklin, TN 37067
Tel: (615) 721-6250
Fax: (615) 721-6251

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Authorization for Use and Disclosure of Protected Health Information (PHI)

This authorization is in accordance with Federal Privacy Laws

Patient information:

Last name _____ First _____ Middle _____
Maiden name _____ Address _____
City _____ State _____ Zip _____
SSN _____ - _____ - _____ Date of Birth ____/____/____ Phone(____) _____ - _____

I, the above identified person, do hereby authorize the release of my PHI as indicated (identify name/group/entity).

FROM: _____

Phone(____) _____ - _____
Fax(____) _____ - _____

TO: **Tennessee Fertility Institute**
9160 Carothers Parkway, Suite 201
Franklin, TN 37067
Tel: (615) 721-6250
Fax: (615) 721-6251

This authorization covers the following periods of healthcare (check one):

- All Periods of Healthcare From ____/____/____ To ____/____/____

Protected Health Information (PHI) to be used or disclosed (check box or boxes):

- Entire Healthcare record Radiology Reports and Images
 Obstetrical Records Previous fertility treatment records
 History/Physical Notes Lab Results (including HIV and STI testing)
 Office Notes/Dictations Consultation Reports
 Surgery Procedure and Pathology Reports Psychotherapy Notes
 Other: _____

This information is being disclosed for the following reasons (check box or boxes):

- Continued Care/Treatment Workman's Compensation
 Patient Request Personal Use
 Obstetrical Care Disability
 Legal Reasons Other: _____
 Insurance

This Authorization will expire in one year unless otherwise specified:

I understand that I/my legal representative may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization or according to law. Written revocation must be sent to the person that I authorized to release my information.

I hereby certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

Patient Signature _____ Date ____/____/____