

MRN

NAME

DOB

Patient stamp above



UT Medical Group, Inc.
Dr. Dan C. Martin
Gynecology and Infertility
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Germantown, Tennessee 38138-1733
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Authorization to Use or Obtain Health Information

Please PRINT or TYPE and return completed form to the above address.

Patient Name: \_\_\_\_\_

The records may be under the previous name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ — \_\_\_\_\_ — \_\_\_\_\_

1. With regard the information identified in Section 3 below, I authorize UTMG to (a) use, and/ or (b) obtain information from the Name of physician or center that did the tubal sterilization listed here: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

2. The purpose or need for which the information is being disclosed is Review by Dr. Dan C. Martin

3. I authorize the disclosure of following information from my medical record:

Complete medical record Laboratory results Progress notes Immunization record

Other - Tubal ligation operative note and pathology report of \_\_\_\_\_ (date)

4. I understand that the information in my health record may include information relating to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. I understand that I have a right to revoke this authorization at any time by presenting my written revocation to (a) the UTMG Health Information Services Department at 920 Madison Avenue, Suite 415, Memphis, TN 38103, and (b) if applicable, the person/organization identified above in Section 1. I understand that the revocation will not apply to information that has already been used or released under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this Authorization has not been revoked, it will terminate on the following date, event, or condition: \_\_\_\_\_

If I fail to specify an expiration date, event, or condition, this authorization will automatically expire in six (6) months.

6. I understand that I can refuse to sign this authorization. I need not sign this form in order to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may no longer be protected by federal confidentiality rules. If I have questions about uses or disclosures of my health information, I can contact the UTMG Privacy Officer at 66 North Pauline Street, Suite 101, Memphis, TN 38105 and/or, if applicable, the person/organization identified in Section 1 above.

Signature of Patient or Personal Representative\*

Printed Name of Patient or Personal Representative\*

Date

\*Relationship to Patient (if Personal Representative)

\*If Personal Representative, the patient is unable to sign because (check one):

Minor Incompetent Other (explain): \_\_\_\_\_

For Office Use Only

Date received \_\_\_\_\_ All complete Proof of I.D. Signed copy to patient

Received by (employee name): \_\_\_\_\_ Title: \_\_\_\_\_

Completed by (employee name): \_\_\_\_\_ Title: \_\_\_\_\_