

Patient MRN

Name

DOB

Patient stamp above - for HIS use only



UT Medical Group, Inc.
Department of Obstetrics and Gynecology
7945 Wolf River Boulevard, Suite 320
Germantown, Tennessee 38138-1733
901-347-8320 • Fax: 901-347-8325

Authorization to Obtain, Use, and/or Disclose Health Information

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

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

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

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

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

1. I authorize UTMG to obtain and/or disclose a copy of the health information described below (Please check [ ] To be obtained from or [ ] To be disclosed to):

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

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

1(a). Information to be released: [ ] Complete medical record [ ] Laboratory results [ ] Progress notes
[ ] Immunization record [ ] Other (specify) \_\_\_\_\_

1(b). Purpose or need for the information is (optional) \_\_\_\_\_

2. 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.

3. I understand that I can revoke this authorization at any time by sending my written request to: UTMG Health Information Services Department at 920 Madison Avenue, Suite 415, Memphis, TN 38103; (901) 448-4530. Such written revocation will be effective only after receipt and processing by UTMG. If I revoke this authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. I understand that the revocation will not apply to information that has already been obtained, used and/or disclosed 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.

4. Unless revoked, this authorization will expire 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 from the date of my request.

5. I understand that a disclosure of information under this authorization carries with it the potential for re-disclosure by the recipient and that the information may no longer be protected by federal confidentiality rules. If I have questions about the uses and disclosures of my health information at UTMG, I can contact: UTMG Privacy Officer at 66 North Pauline Street, Suite 300, Memphis, TN 38105; (901) 448-6936.

6. I understand that I can refuse to sign this authorization. I need not sign this authorization in order to obtain treatment, payment, or health plan enrollment or eligibility.

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: \_\_\_\_\_