State *of* Franklin
OB/GYN Specialists
A division of State of Franklin Healthcare

301 Med Tech Parkway Suite 200
Johnson City, TN 37604
Phone: 423-794-1300
Fax: 423-794-1820
Email: obgynspecialists@sofha.net

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Address:** _____
DOB: _____ _____
SSN: _____ **Telephone:** _____
Email Address: _____

I give my permission for State of Franklin OB/GYN Specialists to
Please circle one ⇒ **RECEIVE / PROVIDE (SEND)**
my medical records as indicated below.

Facility/person to receive or provide records: _____
Address: _____ **Phone:** _____
_____ **Fax:** _____

RECORDS REQUESTED:
_____ Last 10 Years of Record _____ Lab Results _____ Office Notes
_____ Last 3 Years of Record _____ Radiology Reports _____ Pap Smear
_____ Operative Notes _____ Other – _____
**DATES OF RECORDS REQUESTED: _____

PURPOSE REQUESTED:
_____ Personal Use _____Transfer of Care _____ Dr. to review
_____ Insurance Purposes _____ Other (Must Specify) _____

_____ **(Initial)** **(I understand that this WILL INCLUDE information relating to: Acquired Immunodeficiency Syndrome (AIDS), Human immunodeficiency virus (HIV) infection, Behavioral health service / psychiatric care, and treatment for alcohol and/or drug abuse.**
**** If applicable, the following information SHOULD NOT BE DISCLOSED: _____.**

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. To revoke the authorization, I understand I must contact the following in writing: State of Franklin Healthcare Associates, Attn: Privacy Officer, 2528 Wesley St. Suite 2, Johnson City, TN 37601. Unless otherwise revoked, this authorization will expire on the following date, event, condition or within one year from the time I signed this form: _____
The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. Please be aware that information will not be released to a non-custodial parent unless we have a court order stating otherwise.

_____ _____
Patient Name (print) **Person authorized to sign for patient (print)**

_____ _____
Patient's Signature **Signature / Relationship to patient**

_____ _____
Date **Date**