

**Authorization to Disclose Health Information**

Cool Springs OB GYN, P.C.  
1804 Williamson Ct., Suite 208  
Brentwood, TN 37027  
Phone (615) 690-6600

Patient's Name: \_\_\_\_\_ Medical Record Number: \_\_\_\_\_

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

1. I hereby authorize Cool Springs OB GYN, P.C. or \_\_\_\_\_  
1804 Williamson Ct., Suite 208 \_\_\_\_\_  
Brentwood, TN 37027 \_\_\_\_\_  
Phone (615) 690-6600 Phone \_\_\_\_\_  
Fax (615) 690-6605 Fax \_\_\_\_\_

To disclose the health information on the above named patient to, as described below:

\_\_\_\_\_ or Cool Springs OB GYN, P.C.  
1804 Williamson Ct., Suite 208  
Brentwood, TN 37027  
Phone (615) 690-6600  
Fax (615) 690-6600

2. Reason for this request  
\_\_\_\_ Second Opinion \_\_\_\_\_ Moving  
\_\_\_\_ Insurance Request \_\_\_\_\_ Disability  
\_\_\_\_ Changing Doctors \_\_\_\_\_ Other \_\_\_\_\_

3. The type and amount of information to be disclosed is as follows:  
\_\_\_\_ All \_\_\_\_\_ Labs  
\_\_\_\_ Progress \_\_\_\_\_ Other \_\_\_\_\_

Related to services provided during the following period of time: \_\_\_\_\_

Information to be excluded from this authorization: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), or records from other healthcare providers. I may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials: \_\_\_\_\_

4. The patient or the patient's representative must read the following statements:

A. I understand that this authorization will expire: Sixty days from the date of signing; or  
Upon the happening of the following events: \_\_\_\_\_

B. I understand that I may revoke this authorization at any time. I also understand that the Notice of Privacy Practices explains how I may revoke my authorization.

C. I understand that authorizing the disclosure of this health information is voluntary and that I may refuse to sign this authorization and I do not need to sign this form in order to ensure treatment.

D. I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Chemical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the redisclosure.

E. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.

5. Records are routinely mailed. Personal I.D. is required when records are picked up.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
If signed by a Legal Representative, Relationship to Patient

\_\_\_\_\_  
Date

The authorization must be signed by the patient if 18 years or over, or by a minor (under18). If emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor or by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a MR-15 Effective 04/13/03 FCC-065