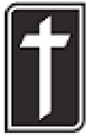

Center for Pelvic Health

A Member of Saint Thomas Health Services

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ____________________________________

DOB: ____________________ SS#: ________________

Telephone #: _____________________________________

Provider releasing information: ____________________________________

Address/Telephone/Fax: ____

Release my Medical information to: **Center for Pelvic Health**
4601 Carothers Parkway, Suite 350
Franklin, TN 37067
Fax # (615) 284-4668

This authorization applies to the following information:

All records __________ Other (specify) ______________________________

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and or alcohol abuse, and HIV information.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

Yes: _____ No: _____

This authorization is valid for 1 year from the date of the patient's or patient's representative's signature unless otherwise specified.

____________________________________ ________________
Signature of patient or patient representative Date

Barry Jarnigan, MD Jennifer Tatalovich, MD Amy Hull, WHNP
4601 Carothers Parkway Suite 350 Franklin, TN 37067 615-284-4664 Fax 615-284-4668