Center for
Pelvic Health

A Member of Saint Thomas Health Services

4601 Carothers Parkway Suite 350
Franklin, TN 37067
615-284-4664

Patient Authorization for Use and Disclosure of Protected Health Information

1. By signing this Authorization, I authorize **Center For Pelvic Health** to disclose protected health information to the following individual(s)for the purpose of keeping them informed about my condition and treatment, and I understand that these disclosures are in addition to those disclosures described in the Notice of Privacy Practices:

Name: ___________________________________ Relationship: ___________________________

Method of Communication: ____

Name: ___________________________________ Relationship: ___________________________

Method of Communication: ____

2. May we contact you regarding your protected health information, health status, appointments, and test results?

_____ Yes, you may contact me by email, my address is ___________________________

_____ No, do not contact me by email for this purpose.

_____ Yes you may contact me by phone, my daytime phone numbers are:

(_____) ___________________ (_____) ___________________

Can we leave a message regarding your protected health information at the numbers you provided above?
________ Yes ________ No

_____ No, do not contact me by phone for this purpose.

3. May we send you newsletters and other marketing information by email?

____ Yes, please use the following email address: ___________________________

____ No, I do not want to be sent newsletters or other marketing information.

I understand that I do not have to sign this Authorization in order to receive treatment and revocation of any authorizations will not affect my ability to continue receiving treatment.

I understand that once my health information is disclosed to a third party, that party may disclose my information to other parties and any re-disclosures of my health information by a third party may no longer be protected under federal or state privacy laws.

I understand that protected health information may include information relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia or HIV infection.

I understand that this Authorization will remain in effect until I am terminated in writing as a patient of this practice or until I submit a written request to revoke this Authorization to the address above or send an email to the address at the top of this Authorization. However, any disclosure that occurred prior to the date of the revocation will not be affected.

I understand that no protected health information (other than as outlined by the Health Insurance Portability and Accountability Act and in the Practice Notice of Privacy Practices, a copy of which I have received) can be released to anyone, including spouses, parents, other family members, significant others or friends without this Authorization.

Patient Signature: ___________________________ Date: ______________________________

Printed Patient Name: ___________________________ DOB: ______________________________

Signature of Patient Representative: ______________________________ Date: ________________

Printed Name of Patient Representative: ________________________ Relationship: ____________________