DR. GRAYSON
WOODS GYNECOLOGY
FOR A HEALTHY YOU

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

SSN: _____ Address: _____

I authorize the release of my medical records to: _____

Address: _____

Phone/Fax number: _____

I authorize the release of my medical records from: _____

Address: _____

Phone/Fax number: _____

For the following purposes: _____

The authorization will expire on (date or event may not exceed one year): _____

This request and authorization applies to:

☐ All medical records

☐ Health care information relating to the following treatment, condition, or dates of treatment:

_____

_____

☐ Specific records to be released (eg Labs, Imaging Reports, Other) :

_____

_____

I understand that I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carriers with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Signature of Patient or Authorized Representative: _____ Date Signed: _____

Relationship to Patient: _____

Phone: 615-630-6969
Fax: 615-630-6968
doctorwoods.com

4322 Harding Pike
Suite 329
Nashville, TN 37205