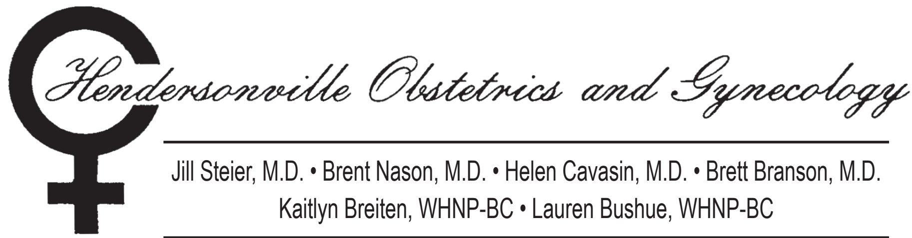

Jill Steier, M.D. • Brent Nason, M.D. • Helen Cavasin, M.D. • Brett Branson, M.D.
Kaitlyn Breiten, WHNP-BC • Lauren Bushue, WHNP-BC

353 New Shackle Island Road, Suite 221 B • Hendersonville, TN 37075
www.hendersonvilleobgyn.com • Phone: 615-822-3880 • Fax 615-264-1664

Request for an Individual's Health Information

Last: ______ **First:** ______ **Middle:** ______

Date of Birth: ______ **Social Security#:** ______

Address: ______

Home Phone: (   ) ______ **Cell Phone: (   )** ______

☐ **Most recent Progress Note** ☐ **Entire Health Record** ☐ **Pathology/Lab Reports** ☐ **Other**______

☐ **I will pick up copies of my records** ☐ **Fax to number below:** ☐ **Mail copies to the individual below:**

Records From:	Records To:
Name:	Name:
Address:	Address:
Address 2:	Address 2:
Phone:	Phone:
Fax:	Fax:

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one (1) year from date of signature.

- **The information authorized for release may include information which may indicate the presence of a communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency virus also known as acquired immune deficiency syndrome (AIDS).**

- The information authorized for release also may include protected health information related to mental health.

- All medical information is protected by the Privacy Act of 1974 and federal or state law or regulations. It will not be given to other persons or organizations unless the law or regulations allow or require us to give out that information, or you allow us to give out that information. If we are required or permitted to give out the information about your medical/health records, it may not be protected if the person or organization that receives it is not required by law to protect the information.

______
Signature of Patient, Parent, or Legal Representative

______
Date

______
Printed name of Patient, Parent, or Legal Representative

______
Relationship to Patient