PARTNERS IN WOMEN'S HEALTH

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

NAME _____

DOB _____ SS# _____

ADDRESS _____

_____

Robert C. Zoller, M.D.
James W. Forrester, M.D.
James M. Link, M.D.
Shannon A. Thomas, M.D.
Kimberly A. Kernek, M.D.
Tracey B. Kuntz, M.D.
Jean H. Nusz, M.D.

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO / FROM

PARTNERS IN WOMENS HEALTH
3940 DUPONT CIRCLE
LOUISVILLE, KENTUCKY 40207
FAX (502) 895-1085

INFORMATION TO BE RELEASED:

___ ENTIRE RECORD

____ OTHER (SPECIFY DATES AND TYPE OF REPORT)

_____

PURPOSE OF REQUEST: _____

_____

TO / FROM: _____

ADDRESS: _____

_____

I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. TO REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE HEALTH INFORMATION MANAGEMENT PERSONNEL. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION OR INFORMATION DISCLOSED FOR THE PURPOSE OF RECEIVING REIMBURSEMENT FROM A THIRD PARTY PAYER.

UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED _____

PATIENT SIGNATURE: _____

DATE: _____