COVENANT HEALTHCARE FOR WOMEN, PLLC

301 North University Street, Suite 102
Murfreesboro, TN 37130
(615)867-0034 Phone (615)867-0717

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEATH INFORMATION

By signing this authorization, I authorize Covenant Healthcare for Women, PLLC to use and/or disclose or to receive certain protected health information (PHI) about me to/from

______________________________ located at ______________________________
Name of entity to receive or send this information

____.

Other entities should send records to Covenant Healthcare for Women. This authorization permits Covenant Healthcare for Women, PLLC to use and/or disclose the following individually identifiable health information about me:

My entire medical record with the exception of the item(s) checked below:

- Substance abuse, if any
- Psychological or psychiatric conditions, if any
- AIDS/HIV, if any
- Other: ____
  ____

The purpose of this request is "at the request of the individual," unless otherwise stated. The purpose is provided so that I can make an informed decision whether to allow release of the information. This authorization will expire ninety days from the date of signature below.

I do not have to sign this authorization in order to receive treatment from Covenant Healthcare for Women, PLLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: 301 N. University St. Suite 102, Murfreesboro, TN 37130.

Signed by: ____
Signature of Patient or Legal Guardian — Relationship to Patient

____
Patient's Name — Date

____
Print Name of Patient or Legal Guardian — Signature of Witness

______________________ ______________________
Patients Social Security Number — Patient's Date of Birth