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Physicians:
James Shirk, MD
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Richard Thigpen, MD
Heather Moss, MD
Michael Bullen, MD
Jamie Perry, MD

Nurse Practitioners:
Ramona Scott, DNP
Susan Houchins, FNP-BC

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Authorization for Release of Protected Health Information

Patient Name: _____ Chart Number: _____

Address: _____ Date of Birth: _____

_____ SS Number: _____

I authorize my protected health information to be:

Released to: _____

Address/Phone/Fax: _____

Obtained from: _____

Address/Phone/Fax: _____

Please specify information to be released / obtained:

___ Complete Record
___ Last Visit
___ OB Records
___ Labs
___ Mammogram
___ Op Notes
___ H&P
___ HIV / STD test(s)
___ Pap / Biopsy
___ Consult

Purpose of release:

___ Continuing medical care
___ Released to patient
___ Insurance coverage
___ Insurance reimbursement

I understand that my medical record may also include information on diagnosis / treatment related to psychiatric or psychological conditions, drug and / or alcohol abuse, acquired immune deficiency syndrome (AIDS), and / or HIV status. I understand and agree that the information, if and, pertaining to any such diagnosis / treatment described above may be released. I understand that my medical record may contain information from other health care providers, which has been filed with my medical record.

_____ _____
Patient Signature *Date*

_____ _____
Witness Signature *Date*

Statement of Time Limitations
I understand that this authorization is valid for ninety (90) days from the date of signature below.
If a longer/shorter period of time is desired please specify the desired time frame in the spaces below.

_____ to _____