

10031 Sherrill Blvd | Knoxville | TN 37932 | p: 865.540.1650 | f: 865.246.4755

_____ **CHART#**

PATIENT NAME _____
(FIRST) (MIDDLE) (LAST)

I have reviewed and/or received a copy of the Notice of Privacy Practices for Contemporary Women's Health, PLLC and authorize the release of my Protected Health Information and Financial Information as outlined in the policy. This authorization will remain in effect until revoked in writing. A photocopy of this release is to be considered as valid as the original.

Contemporary Women's Health, PLLC has my permission to discuss my protected medical information with:

**What phone number should we use to leave a message for you to call our office regarding medical or financial information?
(INCLUDING LEAVING NORMAL TEST RESULTS WITH PERSON OR ON VOICE MAIL)**

WHOM CAN WE SPEAK WITH REGARDING YOUR MEDICAL AND FINANCIAL INFORMATION?

Patient only Phone # (_____) _____

Other Name _____ Relationship _____

Phone# (_____) _____

Signature of Patient _____ Date _____

Signature of patient representative (Required if the patient is an adult who is unable to sign this form)

Relationship _____