NORTH PARK OB-GYN ASSOCIATED, PC
2051-A HAMILL ROAD, SUITE 400
HIXSON, TN 37343-4026

Andrew R Jones, MD
Gerald I Jones, MD

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INDIVIDUAL AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

I hereby authorize ____
to release, use or disclose information from the health record of:

Patient Name:______________________________ Date of Birth ________________

Address:______________________________ Telephone No:________________

______________________________ Soc Sec No:________________

Covering the period(s) of health care from ____________ to ____________
the following:

_____ **Complete Medical Record(s)**
_____ Discharge Summary
_____ History & Physical Exam
_____ Orders and Progress Notes
_____ X-Rays Reports
_____ Other (Specify)______________________________

_____ Pathology
_____ Laboratory Test
_____ Consultation Reports
_____ Operative Reports
_____ Inspect Records

The information will be used or disclosed for the following purpose(s):

- ☐ To assist in the provision of services, care, and treatment of the individual.
- ☐ At the request of the individual
- ☐ Other: ______________________________

To: North Park Ob-Gyn

Address: 2051 A Hamill Rd, Suite 400
Hixson, TN 37343

Fax: 423-875-8510

You have a right to revoke this authorization by doing so in writing and mailing to the above address above.

Such revocation will be effective to the extent that action has not been taken in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, only to the extent that other law provides the insurer with the right to contest a claim under the policy.

The information used or disclosed under the authorization may be subject to redisclosure by the recipient and may no longer be protected by the regulations that protect individually identifiable health information from use or disclosure by health care providers.

I understand I may inspect and/or copy the signed disclosure of Protected Health Information form.

Date:________________

____
Signature

This authorization expires 1 year from date of signature.

____
Print Name

____
Authority of Personal Representative If Signing for the Individual