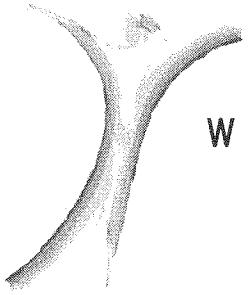

WOMEN'S HEALTH SPECIALISTS

7800 Wolf Trail Cove • Germantown, TN 38138
PH: 901.682.9222 FX: 901.682.9505

Frank Ling, M.D. • Thomas Stovall, M.D. • Robert Summitt, Jr., M.D. • Val Vogt, M.D. • Margaret Summitt, M.D. • Sherri Li, M.D. • Vanessa Givens, M.D. • Michael Edelson, M.D.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Women's Health Specialists to: (circle one) request records from disclose to:

Name: _____ Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

The following information from my medical record: (circle one)

Complete Medical Record Laboratory Results Progress Notes Radiology Results

Other: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

The purpose of this authorization is to permit us to use and disclose all or some of your health information, as you specify, for the limited purpose you describe. We are otherwise required by Federal Law to maintain the privacy of your health information as described in our Notice of Privacy Practices. Your ability to receive treatment, payment enrollment in a plan, or eligibility for benefit normally does not depend on you signing this form. We must have your signature in order to disclose your protected health information.

Expiration: I understand that unless I revoke the authorization earlier, the authorization will expire six (6) months after the date this authorization is signed.

_____ _____

Signature of Patient or Representative | Printed Name of Patient or Representative

_____ _____

Date | Relationship to Patient (if Representative Signs)