WOMENS GROUP OF FRANKLIN, PLLC
4323 CAROTHERS PARKWAY, SUITE 208
FRANKLIN, TN 37087

RELEASE OF BILLING AND MEDICAL INFORMATION

Date: _____

1, _____, authorize the Physicians and Providers of Womens Group of Franklin or their staff to release information on file regarding my medical bills and/or my medical treatment to the person(s) listed below. I understand that by signing this release that the designated person(s) will be able to speak with any staff member of Womens Group of Franklin, PLLC regarding my protected healthcare information (PHI).

Furthermore, I understand that the physician's office cannot be held liable for any information the below stated person(s) may obtain regarding my medical care.

I understand that revocation of this authorization must be provided to Womens Group of Franklin in writing.

Womens Group of Franklin, PLLC, may release medical/billing information to the following specified persons other than myself:

* To my Spouse, _____, ☐ Yes, ☐ No

* To my Partner, _____, ☐ Yes, ☐ No

* Other, _____, ☐ Yes, ☐ No

Relationship: _____

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date