1800 CHURCH STREET SUITE 100
NASHVILLE, TN 37203
PHONE: (615) 329-3624
FAX: (615) 329-0639

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal privacy regulations.

PATIENT NAME: _____ **DOB:** _____

Persons/organizations providing the information: **Persons/organizations receiving the information:**

_____ _____

_____ _____

_____ _____

Specific description of information: _____

What is the purpose of the use or disclosure? _____

(NOTE) "At the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose.

****

I understand that this authorization will expire on __/__/__ or with the following event:

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively. **PATIENT INITIALS:** _____

Must by completed for all authorizations

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative on behalf of the individual, please complete:
Personal Representative's Name: _____
Relationship to Individual: _____