410 N. Parrish Pl.
Ste 2000
Hendersonville, TN 37075
Ph (615) 826-2080
Fx (615) 822-3213

1370 Gateway Blvd.
Ste 110
Murfreesboro, TN 37129
Ph (615) 890-9008
Fx (615) 890-0193

5505 Edmondson Pk
Ste 104
Nashville, TN 37211
Ph (615) 331-5898
Fx (615) 331-5705

7020 Berry Farms Xing
Ste 101
Franklin, TN 37064
Ph (615) 393-6731
Fx(615) 393-6813

4720 Traders Way
Ste 600
Thompsons Station, TN 37179
Ph (615) 302-1279
Fx (615) 302-5279

TENNESSEE PEDIATRICS

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

I hereby authorize the use or disclosure of my health information as described below. I understand that 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 **Date of Birth**

Practice / Physician providing the information:

_____

_____

_____

_____

Practice / Physician receiving the information:

_____

_____

_____

_____

☐ All Medical Records at this Facility

☐ Other (Please Specify):_____

_____

Purpose of the use or disclosure: ☐ At the request of the individual ☐ Changing Physician

☐ Moving ☐ Physician/Staff Request ☐ Other _____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with the following exceptions:

1. The provision of research related treatment for which protected health information is created, my refusal may result in the physician declining to provide the research related treatment.
2. The provision of healthcare that is solely for the purpose of creating protected health information for disclosure to a third party, my refusal may result in the physician declining to provide the service to create said protected health information.

This authorization will expire on _____ ***(Expiration Date or Defined Event*).**

I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to the designated Privacy Officer.

Signed by: _____ _____

Signature of Patient or Legal Guardian **Relationship to Patient**

_____ _____

Print Name of Patient or Legal Guardian **Date**