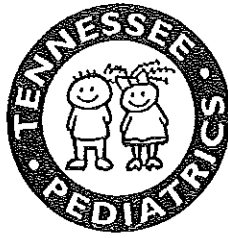


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PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

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