METROPOLITAN PUBLIC HEALTH DEPARTMENT OF NASHVILLE
AND DAVIDSON COUNTY
2500 Charlotte Avenue Nashville, Tennessee 37209

RELEASE OF MEDICAL RECORD INFORMATION

PATIENT'S NAME: _____

DATE OF BIRTH: _____ PATIENT'S FOLDER# : _____

ADDRESS: _____

_____

STATEMENT OF AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION:

I, _____ hereby authorize the
(Name of Patient, Parent, or Authorized Representative)
METROPOLITAN NASHVILLE DAVIDSON COUNTY PUBLIC HEALTH DEPARTMENT to release and/or receive information (including facsimile transmission) relative to my medical record and/or lab results.

☐ Myself ☐ My child _____ (Name) ☐ Authorized Representative _____ (Name)

INFORMATION TO BE DISCLOSED: *The information to be disclosed includes only those items checked below for services provided on or around* _____.

Medical/ Clinic Record Information

- ☐ Discharge Summary
- ☐ STD Clinic Record
- ☐ Lab Results
- ☐ History and Physical Examination
- ☐ Consultation Reports
- ☐ X-Ray Reports
- ☐ HIV/ AIDS Test Results and Treatment
- ☐ Alcohol and Drug Treatment Records
- ☐ Immunization Records
- ☐ Progress Notes
- ☐ TB Clinic Record
- ☐ Photographs, Videotapes, Other Images
- ☐ Mental or Behavioral Health Records
- ☐ Psychotherapy Notes
- ☐ Genetic Test Results
- ☐ Entire Medical Record
- ☐ Family Planning/ Prenatal Record

Other (*please specify*): _____

☐ The following billing and payment information _____

The purpose of the use or disclosure is:

☐ At the request of the patient ☐ Other: _____

THE ABOVE INFORMATION IS TO BE *DISCLOSED* TO/FROM THE FOLLOWING PERSONS OR ORGANIZATION:

NAME: _____

ADDRESS: _____

This release is valid until the close of business on : _____ _____, _____

Signature of Patient/Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the Metropolitan Davidson County Public Health Department. However, the revocation will not have any effect on any uses or disclosures the Public Health Department may have made before the revocation was received.

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

Redisclosure: I understand that any information used or disclosed in accordance with this authorization may no longer be protected by federal law, and could be redisclosed by the receiving party.

Refusal to Sign: I understand that I may refuse to sign this authorization and that the Metro Public Health Department will not condition treatment on whether I sign this authorization.

Certification: I certify that I am *(check whichever applies):*

☐ The patient and the identification that I have provided is true and correct.

☐ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct. My relationship to the patient is that of: _____

Signature: _____

Print Name: _____

Address: _____

_____

Phone #: _____

Witness: _____

Print Name: _____

Date: _____

(ONE COPY TO BE RETAINED BY THE PATIENT)

For Office Use Only:

Name of Clinic: _____

Date received: _____ Expiration date: _____

How was identity verified? _____ Copy made? Yes ☐ No ☐

How was authority verified? _____ Copy made? Yes ☐ No ☐

By: _____ Title: _____ Date: _____