



# Authorization for Disclosure of Health Information

Patient Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient's Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code \_\_\_\_\_

**I, the undersigned, hereby:**

**Authorize Children's Clinic East** to release my/my child's medical information to the following person/organization:

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Authorize \_\_\_\_\_ at \_\_\_\_\_ to release my/my child's health records to

Name of Provider Phone/Fax

- Children's Clinic East; 3901 Central Pike, Suite 251; Hermitage, TN 37076 (615) 232-8033; Fax (615) 885-7838
- Children's Clinic East; 2025 N. Mt. Juliet Rd., Suite 200; Mt. Juliet, TN 37122 (615) 773-7277; Fax (615) 234-7650
- Children's Clinic East, 103 Physicians Way, Suite 100; Lebanon, TN 37090 (615) 466-9770; Fax (615) 466-9782

**Information to be released:**  Entire record  Immunization Record Only  Most recent physical

Health care information relating to the following treatment, condition, or dates of treatment: \_\_\_\_\_

Specific records to be released, e.g., labs, imaging reports, other \_\_\_\_\_

**Purpose or need for the disclosure of records is:**

- Continued medical care  Insurance  Patient's own use  Legal
- Transfer to another provider  School  Other \_\_\_\_\_

- I understand that authorizing the disclosure of this health information is voluntary.
- Refusal to sign this form will not adversely affect my or my child's ability to receive health care services, reimbursement for services, enrollment in a health plan or my eligibility for health benefits.
- I acknowledge that the information disclosed because of this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law.
- I have the right to revoke this authorization by written notice to the Privacy Officer of the practice listed above.
- I understand the actions taken due to this authorization cannot be reversed, and my revocation will not affect those actions.
- The person signing this release may copy the health information disclosed.

**Expiration:** This authorization expires 90 days from the date signed below unless another date or event is entered here \_\_\_\_\_

**Fees:** I understand and agree that there may be costs associated with this request in compliance with State copying laws. These fees must be paid in advance of the release.

**Signature of Minor Patient required for the following records:** A minor patient's signature is required to release the following information: 1) Information related to reproductive care such as birth control, pregnancy-related services and sexually transmitted disease, including HIV/AIDS (age 16 and older) 2) Substance abuse and mental health treatment (age 16 and older).

\_\_\_\_\_  
Signature of Minor Patient \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent / Legal Guardian \_\_\_\_\_  
Date

**My relationship to patient:**  Parent  Guardian  Other (specify) \_\_\_\_\_