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: ____

☐ 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) ____