Nashville Orthopaedic Specialists, PC

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

I, _________________________, hereby authorize: _____________________________________
to disclose health information regarding the following patient

Patient name: ___________________________ Date of Birth: _____________________

Address: _______________________________ Patient's Phone: ___________________
_______________________________ Social Security#: ___________________

1. The information is to disclosed to the following persons or organizations:
   Name:
   Address:

2. **Purpose**: The purpose of the use or disclosure is:
   [ ] at the request of the patient
   [ ] other ____
   If the purpose is for marketing, will the practice receive direct or indirect compensation or payment in return for using or disclosing the patient's health information? [ ] YES [ ] NO

3. **Information to be disclosed**. The information to be disclosed includes only those items checked below with respect to services provided on or around ________ (insert date)
   The following medical records:
   [ ] Entire Medical Record
   [ ] Lab results
   [ ] Consultation Reports
   [ ] Summary of treatment
   [ ] Progress Notes
   [ ] History & Physical exam
   [ ] X- Ray Reports
   [ ] Discharge summary
   [ ] Other ____
   ____

4. **Revocation**. I understand that I may revoke this authorization at any time by sending a written notice to the Practice. However, the revocation will not have any effect on any uses or disclosures the Practice may have made before the revocation was received.

5. **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.

6. **Re-disclosure**. I understand that the information used or disclosed in the accordance with this authorization may no longer be protected by federal law and could be redisclosed by the receiving party.

7. **Refusal to sign**. I understand that I mat refuse to sign this authorization and that the Practice will not condition treatment on whether I sign this authorization.

8. **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 authority that I have provided are true and correct. My relationship to the patient is that of:
   ____

Signed this ________________ day of _________, 200__

Signature: ________________________________
Print name:________________________________

Witness: _______________________
Print Name: ____________________
Date: _________________________