METROPOLITAN PUBLIC HEALTH DEPARTMENT OF NASHVILLE AND DAVIDSON COUNTY
311 23RD AVENUE NORTH NASHVILLE, TENNESSEE 37203

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

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: _________________________________ Witness: __________________________________

Print Name:________________________________ Print Name:_________________________________

Address: _________________________________ Date: __________________________________

____

Phone #: _________________________________

(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: _______________