NASHVILLE HIP INSTITUTE
Preservation, Reconstruction & Sports Medicine

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Nashville, TN 37203
615-284-5800
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize the disclosure of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____ Date of Birth: _____

(Select To or From)

☐ To ☐ From Nashville Hip Institute
2004 Hayes Street, Suite 700
Nashville, TN 37203
615-284-5800 fax: 615-284-5819 email: kathleen@nashvillehip.org

☐ To ☐ From _____

_____

_____

_____

This request and authorization applies to:

☐ All medical records

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

_____

Purpose of disclosure: _____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____
Signature of Patient or Authorized Representative *Date Signed*

The authorization will expire on: _____
Date or Event may not exceed one year