



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 100
Nashville, TN 37203
615-284-5800 fax: 615-284-5819 email: stephanie@nsmoc.com

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