Metro Public Health Dept
Nashville / Davidson County
Protecting, Improving, and Sustaining Health

2500 Charlotte Avenue, Nashville, Tennessee 37209

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	☐ Photographs, Videotapes, Other images (All photos are de-identified)	☐ Progress Notes
		☐ STD Clinic Record
☐ HIV / AIDS Test Results and Treatment	☐ Family Planning / Prenatal Record	☐ TB Clinic Record
☐ Alcohol and Drug Treatment Records	☐ Consultation Reports	☐ Lab Results
☐ History and Physical Examination	☐ Genetic Test Results	☐ X-Ray Reports
☐ Mental or Behavioral Health Records	☐ Entire Medical Record	☐ CHANT
☐ Psychotherapy Notes	☐ 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 PERSON(S) OR ORGANIZATION:

NAME: _____

ADDRESS: _____

This release is valid until the close of business on: _____ _____, _____

MONTH DAY YEAR

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 use or disclosed in accordance with this authorization may no longer beprotected by federal law and could be disclosed 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 Signature: _____

Print Name: _____ Print Name: _____

Address: _____ Date _____

_____

Phone No.: _____

**** ONE COPY TO BE RETAINED BY THE PATIENT ****

For Office Use Only:

Name of Clinic: _____

Date Received: _____ Expiration Date: _____

How was the identity verified? _____ Copy made? ☐ Yes ☐ No

How was the authority verified? _____ Copy made? ☐ Yes ☐ No

By: _____ Title _____ Date: _____