NASHVILLE FERTILITY CENTER, P C
345 23rd Ave. North, Suite 401
Nashville, TN 37203
(615) 321-4740
FAX (615) 320-0240

AUTHORIZATION FORM
FOR RELEASE OF HEALTH INFORMATION

Patient's Full Name:_____ Date of Birth: _____

Address_____City_____State____Zip_____

Phone: (____)_____

I HEREBY AUTHORIZE THE FOLLOWING RELEASE OF MY HEALTH INFORMATION:

Records requested from:	**Send Records to:**
Clinic/Provider	Clinic/Provider
Address	Address
City State Zip	City State Zip
Phone# Fax#	Phone# Fax#

I SPECIFICALLY AUTHORIZE RELEASE OF THE FOLLOWING INFORMATION:

☐ **Entire medical record**

Or check the appropriate box(es):

☐ Discharge Summary
☐ History and Physical Examination
☐ Progress Notes
☐ Laboratory Tests
☐ Ultrasound Reports
☐ Consultation Reports
☐ TSH, Rubella, Blood Type, Prolactin
☐ Photographs, video, digital or other images (if available)
☐ Health care information related to the following treatment, condition, or dates of treatment:_____

_____.

1. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

2. I understand that I have the right to revoke this authorization at any time by presenting my written revocation to Nashville Fertility Center at the above address. I understand that the revocation will not apply to information that has already been used or disclosed under this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. If this Authorization has not been revoked, it will terminate on the following date, event, or condition:

_____ If I fail to specify an expiration date, event or condition, this authorization will automatically expire in six (6) months.

3. I understand that I can refuse to sign this authorization. I need not sign this form to obtain treatment, payment, or health plan enrollment or eligibility. I understand that any disclosure of information carries with it the potential for redisclosure by the recipient and that the information may then no longer be protected by federal confidentiality rules. If I have questions about uses or disclosures of my health information, I can contact Nashville Fertility Center at the above address.

4. I understand that I may inspect a copy of the Protected Health Information to be used or disclosed and will receive a copy of this form once signed. _____ (Patient initials)

5. I understand I will be charged a fee for faxing or photocopying and mailing my records. (Charges are $20.00 for the first 5 pages and $0.50 for each additional page + postage fee; payable by check, Mastercard, or Visa.)

_____ _____
Signature of Patient or Legal Representative (relationship) Date

Revised 04/25/13