Southern Pediatrics
740 Cool Springs Blvd.
Suite 140
Franklin, TN 37067
www.southernpeds.com

Authorization to Release PHI/Medical Records

Patient's Name:_____

Patient's Date of Birth:_____

Signee's Relationship to Patient:_____

Release Records from:	Release Records to:
Facility/ Physician:	Facility/ Physician:
Address:	Address:
Phone Number:	Phone Number:
Fax Number:	Fax Number:

I understand that information in my health record may include information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care and treatment related to drug or alcohol use; my signature authorizes the release of such information.

This authorization expires within 90 days from the date specified, unless I revoke this authorization earlier. I understand that I may revoke this authorization at any time, except to the extent that actions based on this authorization has already been taken. Our Notice of Privacy Practices explains the process of revocation, which includes a request in writing.

Printed name of Parent/Guardian:_____

Date:_____

Signature of Parent/Guarian:_____