Franklin Gastroenterology, PLLC 740 Cool Springs Blvd., Suite 210
Franklin, Tennessee 37067
Phone 615-771-8786 Fax 615-771-2801

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hear by authorize _____to release or disclose to the below Named recipient all 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: _____

I hear by authorize the release of medical records to: _____

_____

Purpose of disclosure: _____

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

This request and authorization applies to:

_____ All medical records

_____ Specific records to be released (e.g. Labs, imaging reports, other):

_____

I would like to have these records sent by: □ Fax □ Email (only if sending directly to patient)
□ Mail

I understand I have the 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 this authorization.

_____

Signature of Patient or Authorized Representative Date Signed

_____

Relationship to Patient