TURNER SURGERY CENTER

28 White Bridge Pike STE 210
Nashville, TN 37205
Phone: 615-492-1142
Fax: 615-434-8111

Authorization for Release of Medical Records

Patient Information

Full Name: _____

Date of Birth: _____ Last 4 SSN: _____

Phone Number: _____

Address: _____

_____

Release Information

☐ I authorize Turner Surgery Center to release my medical records

☐ I authorize Turner Surgery Center to obtain my medical records

TO / FROM (Circle One):

Name/Facility: _____

Address: _____

_____

Phone: _____ Fax: _____

Purpose of Request

☐ Continuation of Care
☐ Legal
☐ Personal
☐ Insurance
☐ Other: _____

Information to Be Released

(Initial all that apply):

_____ Operative Reports
_____ Pathology Reports
_____ Anesthesia Records
_____ Billing Records
_____ History & Physical
_____ Entire Medical Record
_____ Other: _____

Delivery Method

☐ Paper Copies

☐ Fax

☐ Other: _____

Authorization and Signature

I understand that:

- This authorization is valid for one year from the date signed unless I revoke it earlier in writing.
- I may revoke this authorization at any time in writing.
- Treatment or payment is not conditioned on signing this form.
- Information disclosed may be subject to re-disclosure and no longer protected by HIPAA.

Signature of Patient or Legal Representative: _____

Date: _____

If Signed by Legal Representative:

Name: _____

Relationship: _____

Phone Number: _____

FOR OFFICE USE ONLY

Date Request Received: _____

Records Released By: _____

Date Released: _____

Method of Delivery: _____