NASHVILLE UROLOGY

MEDICAL RECORD RELEASE

T: 615-270-8060 | F: 615-628-1344 | 2201 Murphy Ave Suite 115 Nashville, Tn 37203

Name of Patient: _____ __ **Phone**: _____**D.O.B**_____

I, _____hereby authorize:

Name of facility: _____

Name of Provider: _____

Phone: _____ **Fax**: _____

Address: _____

City, State, Zip: _____

To release the following specific medical information **to** Nashville Urology, P.C. by:

- ○ Mail: 2201 Murphy Ave Suite 115 Nashville, TN 37203
- ○ Fax: **615-628-1344**

My authorization extends only to those data elements/ documents indicated below:

- ○ **Statements of charge or payments**
- ○ **Records of visits (All visits)**
- ○ **Record of visit for the dates of or through _____**
- ○ **Copies of records or reports provided to the above named (i.e. hospital, lab, clinic, etc..)**
- ○ **All the above**
- ○ **Other (Specify): ___Imaging Records____**
- ○ **Mental Health and/or alcohol abuse treatment**
- ○ **HIV information**
- ○ **Hepatitis information**

This authorization is given freely with the understanding that:

1. **All records, whether written or oral in electronic format, are confidential and cannot be disclosed without prior written authorization, except otherwise provided by law.**
2. **That a photo copy or fax of this authorization is a valid as this original.**
3. **That a potential exists for information I authorize to be redisclosed by the recipient.**
4. **That I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a sixty-day (60) period from the date it is signed, or sooner if noted below.**

Patients name (PRINTED):_____ ___ Social security number: _____

_____ _____

Patient signature, ***legal representative or Patients parent or guradian if under 18.*** **Date**