Nurture Pediatrics
810 Medical Park
Smyrna, TN 37167
Clinic-615-223-5565
Fax-615-223-5509

Authorization for Use/Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby voluntarily authorize the use/disclosure of information from my health record.

The information is to be disclosed by: **Nurture Pediatrics, PLLC**

The information is to be provided to: _____ _____
Person/Facility to Receive Records Phone Number

_____ _____ ____ _____
Street Address City State Zip

The information to be disclosed from my health record: (check appropriate box)

☐ Entire record

☐ Only information related to (specify) _____

☐ Only dates of service from _____ to _____

☐ Other (specify) _____

If you would **NOT** like any of the following sensitive information disclosed, check boxes that apply:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☐ Mental Health: Not including Psychotherapy Notes

(Psychotherapy Notes may only be disclosed with a separate authorization.)

I understand I have the right to revoke this authorization by submitting my request in writing at any time to the Practice. The Practice must comply with my request except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. I understand that this request will expire automatically 12 months after the date affixed below.

Print Patient Name: _____ Patient's Signature: _____

Parent or Guardian Name Print: _____

Parent or Guardian Signature: _____

Relationship to Patient: _____ Date: _____