COOL SPRINGS FAMILY MEDICINE
397 Wallace Rd
Suite 301
Nashville, TN 37211
Phone: (615) 791-9784
Fax: (615) 791-9785
Email: info@csfmed.net

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

		XXX-XX-
Patient Name	**DOB**	**Last 4 of SSN**

Complete Address **Phone #**

I, the undersigned, authorize you to furnish a copy of my medical records:

TO: COOL SPRINGS FAMILY MEDICINE

From Facility:

_____

Address:

_____

City/ State/ Zip:

_____

Phone #: _____

Fax #: _____

FROM: COOL SPRINGS FAMILY MEDICINE

To Facility/Individual:

_____

Address:

_____

City/ State/ Zip:

_____

Phone #: _____

Fax #: _____

____ I acknowledge and hereby consent to such, that the released information may
Init contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.

I, the undersigned, have read the above and authorized the staff of the disclosed facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional authorization on my part. This facility is released and discharged of any liability and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information." This order will remain in effect until revoked by me in writing.

_____	_____	_____
Signature of Patient or Parent/Guardian	**Relationship to Patient**	**Date**