Cool Springs Internal Medicine and Pediatrics Clinic, PLLC

Authorization for Release of Information

I hereby authorize Cool Springs Internal Medicine and Pediatrics Clinic, PLLC to give all information or opinion that may be requested by the following party regarding any physical condition and treatment which has been rendered to me, including diagnosis and prognosis except as noted below. I also authorize the representatives of the below named firm to see and copy any and all records available, including x-rays, lab/test results, and/or hospital records regarding my condition and treatment.

This authorization is valid for 90 days from the date of execution. Executed this ________ day of ________________, 200___, in ____________________ Tennessee. However; I understand that I may revoke this authorization at any time by writing to the medical records department at the address below.

Patient Name: ____

Address: ____

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Date of Birth: ______________

Social Security # _________________________

Release Records To: (Address Must Be Provided)

Name: ____

Address: ____

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Phone: ______________ Fax: _________________

____ ______________

Signature of patient or responsible party Date

____

If responsible party, relationship to the patient

DO NOT SEND THE FOLLOWING RECORDS/INFORMATION: