NASHVILLE
SPORTS MEDICINE
AND ORTHOPAEDIC CENTER

J. W. Thomas Byrd, MD

2011 Church Street
Suite 100
Nashville, TN 37203
615-284-5800
Fax 615-284-5819

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(All sections must be completed)

I hereby authorize the disclosure of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

Patient Name: _____Date of Birth: _____

(Select To or From)

To ☐ From ☐ Nashville Sports Medicine & Orthopaedic Center
2011 Church St., Suite 100
Nashville, TN 37203
615-284-5800 fax: 615-284-5819 email: loraine@nsmoc.com

To ☐ From ☐ _____

_____

_____

_____

This request and authorization applies to:

☐ All medical records

☐ Health care information relating to the following treatment, condition, or dates of treatment:

_____

Purpose of disclosure: _____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____

Signature of Patient or Authorized Representative *Date Signed*

The authorization will expire on: _____

Date or Event may not exceed one year