

Authorization to Release PHI/Medical Records to  
Southern Pediatrics  
Fax: 615-778-1841



740 Cool Springs Blvd.  
Suite 140  
Franklin, TN 37067  
615-778-1840  
Fax: 615-778-1841  
[www.southernpeds.com](http://www.southernpeds.com)

I hereby authorize any physician or person who has attended and examined my child to release for purposes of treatment his/her entire medical record (pursuant to state and federal law), including without limitation, any and all information with respect to any illness, injury, medical history, and/or medical records to:

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dr. Gabriela Morel       Dr. Gordon Davis       Dr. Mark Hughes

**PROVIDER/FACILITY RELEASING RECORDS:**

Their Address: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable disease, Behavioral Health Care and treatment related to drug or alcohol use; my signature authorizes the release of such information.

This authorization expires within 90 days from the date specified, unless I revoke this authorization earlier. I understand that I may revoke this authorization at any time, except to the extent that actions based on this authorization has already been taken. Our Notice of Privacy Practices explains the process of revocation, which includes a request in writing.

I understand that I may refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I understand that if any of the information to be released relates to the treatment for alcohol or drug abuse, there are special requirements for my consent to release as found in Federal Confidentiality Rules (42 CFR Part 2) which prohibit the further release of that information without my consent, as referenced in the federal regulations, or as otherwise permitted by law.

I understand that the provider releasing the PHI/medical record to Southern Pediatrics PLLC cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at releasing provider may or may not protect this information once it has been disclosed to the recipient.

Printed name of Parent / Guardian: \_\_\_\_\_

DATE: \_\_\_\_\_

Signature of Parent / Guardian: \_\_\_\_\_

This patient's record is released for the sole purpose revealed above. Any further release of information, review, dissemination, distribution, or copying of this information is strictly prohibited. **If you receive this message in error, please notify us immediately by phone at (615) 778-1840**

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