EAR, NOSE & THROAT
Specialists of Nashville

Mark A. Williams, M.D., Ph.D.

Authorization to Release Patient Health Information

Patient's Name (Last) ______________________________ (First) ______________________________ DOB ________________

Information to be released ________:	**Information to be released _____:**
Organization ______________________________________	Ear, Nose & Throat Specialists of Nashville, PLC
Address ____	341 Wallace Road Suite D
City ________________________State ________ Zip _______	Nashville, TN 37211
Phone ___________________ Fax ______________________	**Phone 615-832-2200 Fax 615-832-2020**

Information to be Released

☐ Complete Medical Records

☐ Dates of service for records requested: Beginning ________________________ through ________________________

☐ Office Visit ☐ Lab Reports ☐ Other ____

☐ Confer with person(s) listed orally about medical information ____

Purpose of Release

☐ Continuing care ☐ Transfer to a new provider ☐ Personal use ☐ Legal

☐ Other ____

Authorization for General Release of Information

I understand that:

- I may refuse to sign this authorization, and that my refusal to sign will not affect my ability to obtain treatment. **Initial** ______
- This authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance of this authorization.
- The information released may be subject to re-disclosure by some recipients and may no longer be protected by federal and state privacy rules related to health information.
- Per Tennessee Code 63-2-102, the requested facility will provide my records within 15 days from the receipt of this request. The code also allows a fee of .25¢ per page up to 40 pages and .25¢ a page thereafter. The actual cost of postage may also be charged.
- This authorization expires: ____ (if blank, then 90 days after date of signature)
- To revoke this authorization, please send a written request to the Ear, Nose & Throat Specialists of Nashville.

Signature of Patient Legal Representative

__________________ ____ _________________________

Date Signature of Patient/Legal Representative Relationship to Patient