100 Covey Drive, Suite 310, Franklin, TN 37067

Ph: (615) 203-8750 Fax: (866) 854-5230

Name ______________________________ Date of Birth ______________________________

Address ______________________________ Phone Number ______________________________

City, State, Zip Code ______________________________ Last 4 of Social Security Number ______________________________

Relationship ______________________________

I hereby authorize **Southern Pediatrics PLLC,** 740 Cool Springs Blvd, SUite 10, Franklin, TN 37067, to release my medical records to:

Franklin Pediatric Clinic
100 Covey Drive, Suite 310, Franklin, TN 37067
Ph: (615) 203-8750 Fax: (866) 854-5230

This consent and authorization may include, but is not limited to, the release of medical, alcohol and/or drug abuse treatment, psychological, psychiatric, sexually transmitted diseases, and HIV/AIDS information.

I understand that this consent is revocable, except to the extent that action has already been taken in reliance thereon. Request for revocation of this authorization must be in writing and presented to the Medical Records Department. This authorization will expire (i) after 6 months, (ii) after the disclosure is made, or (iii) the date specified here: __________, to accomplish the purpose of the disclosure stated above.

Signature ______________________________ Date ______________

Printed name ______________________________

Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is not longer protected under Title 45, CFR. Nashville Pain and Wellness Center may not condition treatment or payment on whether you sign this authorization. I understand that authorizing this disclosure of health information is voluntary.

REQUEST FOR RELEASE OF MEDICAL INFORMATION