PLEASE FAX OR EMAIL THIS COMPLETED FORM TO:
The Little Clinic LLC Attn: Medical Records Department
Fax: (615) 425-4344 OR medicalrecords@thelittleclinic.com

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Section A: Patient Identification (Required)

Patient Name (please include any maiden name or alias):	Gender:	Date of Birth:	SSN #
Address:			
Home Phone:	Cell Phone:	Work Phone:	
Email:	Home Fax:	Work Fax:	
If requested by Parent or Personal/Legal Representative (Indicate Name & Relationship):			

Section B: Purpose of Use and Disclosure of Personal Health Information ("PHI")

☐ Medical Treatment
☐ Insurance / Billing
☐ Legal Purposes
☐ Other (Specify):_____

Section C: Request for Copy of PHI and Authorization for Disclosure of PHI

You have a right to inspect and obtain a copy of your health information for as long as we maintain the information in our records, with certain limited exceptions. Under certain limited circumstances, we may deny your request to inspect and/or copy your health information. If access is denied, you may request that the denial be reviewed. Instructions for the review process will be included with any denial. You also agree to pay any fees (if applicable) associated with copying, and mailing the above records. Please note that we accept cash or check (for the exact amount); we do not accept credit cards.

Indicate preference: ☐ Please mail the copies I requested to address below (if same as patient, please note)
☐ Please fax copies to number below

I hereby authorize The Little Clinic to release my protected health information to: ☐ Insurance Co. ☐ Physician ☐ Self ☐ Other

Person/Practice/Organization:	Phone:
Address:	Fax:

Section D: Health Information to be Accessed or Disclosed (to be completed by all requestors)

1. Access and/or disclosure shall be limited to the following elements of my health information:

☐ Physical Form ☐ Consultation Reports ☐ Immunization Records

☐ History / Medical Summary ☐ Laboratory Tests ☐ Billing Records

☐ Progress Notes ☐ Pathology Report

☐ Other (specify): _____

☐ All the above (from (date) _____ to (date) _____)

2. Such access or disclosure is limited to the following:

- Type of information (specific medical condition): _____
- From (date) _____ to (date) _____

3. To access or disclose any of the following restricted information, initial the appropriate box(es):

____ HIV Test Result ____ Genetics ____ Fertility ____ Alcohol/Drug Abuse

I understand that I may refuse to sign this authorization and that The Little Clinic may not condition my treatment upon whether I sign this authorization. I understand that if I have authorized the disclosure of information to someone who is not legally required to keep it confidential, the recipient may re-disclose it, and it may no longer be protected. I understand that I have a right to receive a copy of this authorization.

I understand that this authorization is effective immediately and will remain in effect no longer than one hundred eighty (180) days. I reserve the right to withdraw or revoke this authorization, in writing at any time, except to the extent that The Little Clinic has already disclosed the information.

I hereby release, discharge, and agree to hold The Little Clinic harmless from any liability that may arise from the release of information authorized herein.

Name: (Printed): _____

Signature: _____ Date: _____

If signed by other than patient, indicate relationship:_____

A counterpart (by facsimile, photocopy, or electronic) of this authorization shall be considered as valid as the original.

To withdraw or revoke this authorization, submit a written request to the Compliance Officer at The Little Clinic, 2620 Elm Hill Pike, Nashville, TN 37214.