

# VIP MIDSOUTH, LLC

Gallatin Children's Clinic  
648 Hartsville Pike  
Gallatin, TN 37066  
Ph. (615) 451-9246

Station Camp Children's Clinic  
225 Big Station Camp Blvd, Ste 204  
Gallatin, TN 37066  
Ph. (615) 451-7222

Lafayette Children's Clinic  
306 W. Locust St.  
Lafayette, TN 37083  
Ph. (615) 688-7012

White House Children's Clinic  
128 Raymond Hirsch Pkwy, Ste. 1  
White House, TN 37188  
Ph. (615) 672-8118

## Patient Authorization for Practice to Release Protected Health Information to Third Parties

I hereby authorize the use or disclosure of my health information as described below. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by federal privacy regulations.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Practice/Physician to Receive Information: \_\_\_\_\_ Practice/Physician to Release Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Purpose of the use or disclosure:  
At the request of the individual \_\_\_\_\_ Changing Physicians \_\_\_\_\_  
Moving \_\_\_\_\_ Physician/Staff Request \_\_\_\_\_ Other \_\_\_\_\_

I have the right to revoke this authorization in writing except to the extent that the provider has acted in reliance upon this authorization. My written revocation must be submitted to the designated Privacy Officer.

\_\_\_\_ Please release my child's shot record, growth chart, and diagnosis history at no charge.

\_\_\_\_ Please release my child's entire record for a fee of \$20 for the first 5 pages and \$0.50 each sheet starting at page 6. I understand an additional fee may be applied for postage and affidavit.

\_\_\_\_ I would like my records in electronic format

\_\_\_\_ I will pick up requested medical records once notified by office.

\_\_\_\_ I request that medical records be mailed to me at: \_\_\_\_\_  
\_\_\_\_\_

### \*Medical Record Disclosure:

Our office may take up to 10 business days to process this request.

This authorization will expire 30 days from the date signed and only covers treatment prior to that date.

Signed: \_\_\_\_\_  
(Signature of Parent/Guardian/Patient)

Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

Date Signed: \_\_\_\_\_

### Office Use Only:

Date Processed: \_\_\_\_\_ By: \_\_\_\_\_  
Records: Picked Up/Mailed (please circle one)

Fee Paid: \_\_\_\_\_  
Method of Payment: \_\_\_\_\_