

**NOLENSVILLE FAMILY MEDICINE  
JOHN R. THOMPSON, MD**

**940 OLDHAM DRIVE, NOLENSVILLE, TN 37135  
PHONE: 615-776-8088 FAX: 615-776-8012**

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION  
(All sections must be completed)**

I hereby authorize Nolensville Family Medicine and its physicians, employees and agents to release or disclose to the below-named provider all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

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

I hereby authorize the release of medical records to: \_\_\_\_\_  
\_\_\_\_\_

Purpose of disclosure: \_\_\_\_\_

The authorization will expire on: \_\_\_\_\_  
Date or Event may not exceed one year

This request and authorization applies to:

\_\_\_\_\_ All medical records

\_\_\_\_\_ Health care information relating to the following treatment, condition, or dates of treatment:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Specific records to be released (eg. Labs, imaging reports, other):

\_\_\_\_\_

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

\_\_\_\_\_ Substance abuse \_\_\_\_\_ Psychological or psychiatric treatment \_\_\_\_\_ HIV/AIDS/STD

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

\_\_\_\_\_  
Signature of Patient or Authorized Representative

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

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