Belmont University Health Services
1900 Belmont Boulevard
Nashville, TN 37212
Phone: 615-460-5506 Fax: 615-460-6131

Authorization For Release Of Medical Records

____ ____________ ____________
Last Name First Name MI DOB BUID#

____ ____________________
Address City, State, Zip Phone Number

I authorize Belmont University Health Services, Nashville, TN, to use or disclose the above named individual's health information as described below:

____ **Immunization Record** ____ Entire Record ____ Lab Results
____ X-Ray and Imaging Reports ____ Last Visit ____ Other: ______________________

Reason for request (check all that apply):
____ Continuity of care (follow-up) ____ School Transfer ____ Other (Please specify reason) ______________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may include information about behavioral or mental health services and treatment for alcohol or drug abuse. I do **NOT** authorize Belmont University Health Services to disclose any of the following information:

____ AIDS/HIV ____ Alcohol/Drug Abuse ____ Sexually Transmitted Diseases ____ Behavioral/Mental Health

I hereby authorize and request copies of my medical records from:

Name: ______________________________
Address: ______________________________
Phone: ______________________________
Fax: ______________________________

Records released to:

Name: **Belmont University Health Services**
Address: **1900 Belmont Boulevard**
Nashville, TN 37212
Fax: **615-460-6131** Phone: **615-460-5506**

____ I will pick up the copies myself ____ Fax ____ Discuss care

This authorization will expire (1) year following the date signed or upon request.
I understand that I may revoke this authorization at any time, unless the authorization was given as a condition of obtaining insurance coverage; that this revocation must be submitted in writing to the place where I originally submitted this authorization; and that this revocation will take effect except to the extent that the facility has already disclosed information based on this authorization.
I understand that information used or disclosed by this authorization may be subject to re-disclosure again by the recipient and may no longer be protected by the applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I have read and understand this information. I am the patient or am authorized to act on behalf of the patient and sign this document. This verifies that I authorized the use or sharing of the protected Health Information under the terms stated above.

____________ ______________________________
Date Signature of Patient

____________ ______________________________
Date Signature of Legal Representative and Relationship

If patient is unable to sign or is a minor, secure consent of Legal Representative and indicate reason below:

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