C. Andrew Jordan, MD
Board Certified in Pediatrics

L. Chana Spearmon-O'Neal, MD
Board Certified in Pediatrics

Julia Byrd, CPNP-PC
Certified Pediatric Nurse Practitioner

Marie DeThomas, CPNP-PC
Certified Pediatric Nurse Practitioner

Amy Evans, MSN, FNP-BC
Certified Family Nurse Practitioner

Lacey Gober, CPNP-PC
Certified Pediatric Nurse Practitioner

Miranda Green, FNP-C
Certified Family Nurse Practitioner

Brandy Tomlinson, FNP-C
Certified Family Nurse Practitioner

Lebanon Office
1029 W. Main St., Ste. M.
Lebanon, TN 37087
Phone 615-453-1252
Fax 615- 453-1286

Gordonsville Office
8 New Middleton Hwy.
Gordonsville, TN 38563
Phone 615-683-4200
Fax 615-683-4207

Hartsville Office
333 East McMurry Blvd
Hartsville, TN 37074
Phone 615-549-7737
Fax 615-549-7734

Visit our website:
cumberland-pediatrics.com

Authorization for Disclosure of Protected Health Information

Patient Contact Information

Name: _____ Date of Birth: _____

Address: _____

Phone: _____

Reports to be Disclosed:

___Complete Medical Record ___Laboratory Reports ___Operative Reports
___Imaging Reports ___Immunization Records ___HIV Test Results
___Other (Please Specify) _____

Records Released To / From:

Name: _____ Phone: _____

Address: _____

Fax: _____

Reason for Release: _____

I authorize the third party named in the above section to disclose the protected health information about myself (or the patient) as described about. I understand:

- This expiration expires 180 days from the date of my signature unless I specify otherwise. Expiration: _____
- I may revoke this authorization at any time by notifying Cumberland Pediatric Associates in writing. If I revoke this authorization, I understand that it will have no effect on actions Cumberland Pediatric Associates took in good faith before receiving the revocation.
- The information released may contain information related to AIDS or HIV infection: drug or alcohol use; mental or behavioral health or psychiatric care, except for psychotherapy notes.
- Cumberland Pediatric Associates may not condition treatment or payment on my completion of this form.
- Cumberland Pediatric Associates reserves the right to verify my identity or guardianship.

Signature _____

Printed Name: _____

Relationship to Patient: _____ Date _____