SUSAN BRILEY, MD
colorectal surgery

PERMITTED DISCLOSURES

I hereby authorize the disclosure of my health information to be given to the following people and/or physicians.

_____ _____
Name Relationship

Physicians:

_____ _____
Name Phone Number

_____ _____
Name Phone Number

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security# _____

I request and authorize _____

To release my healthcare information to:

Name: **Susan Briley,M.D.**

Address: **2004 Hayes St, Ste#550**

City: **Nashville** **ST: TN** **Zip: 37203**

Phone: **615-284-4224** **Fax: 615-284-4225**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Patient Signature: _____ Date: _____

Revised 08/2016