

KNOXVILLE PEDIATRIC ASSOCIATES, P.C.
RECORDS RELEASE AUTHORIZATION

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AND 9017 Cross Park Drive, Suite 200
Knoxville, TN. 37923
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There is a fee of \$20 for the first forty (40) pages or less of the medical record and a per page charge of 25¢ for all pages thereafter. There is NOT a charge to release records directly to another physician.

Release records to (name, address, phone):

Release records from (name, address, phone):

Please release records on the following patient(s):

Name(s) _____ **Date of Birth** _____

Reason for records release (please check):

Moving Dissatisfied with physician
 Graduated from pediatrics Dissatisfied with staff:
 Insurance Front office Nurse Business Office
 Wait times **specify** (waiting room, in room, nurse line, appt line) (comments) _____
 Other _____

*****It is our goal to improve our practice and better serve our patients so any comments are appreciated*****

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORDS RELEASED, PLEASE READ THIS SECTION CAREFULLY AND SPECIFY BELOW THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE, YOUR COMPLETE RECORDS WILL BE RELEASED.

I authorize the health care provider to release the information specified to the organization, agency, or individual named on this request with the EXCEPTION of substance abuse, psychological or psychiatric conditions, AIDS/HIV, etc, **please specify** _____

Expiration or revocation of authorization - I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below.

Treatment, payment, enrollment, or eligibility of benefits-Is not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization.

Information - Once the information is used or disclosed, it may no longer be protected.

Use of copies - A copy of this authorization may be utilized with the same effectiveness as an original.

My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Signature _____ **Date** _____ **Relationship to child** _____
Print Name _____

Office Use Only

(Driver's License/photo ID must be presented)

Driver's License number/ID number of individual records released to: _____

Date records released: _____ Relationship to patient: _____

Amount charged for records: _____ Employee Initials: _____