KNOXVILLE PEDIATRIC ASSOCIATES, P.C.

RECORDS RELEASE AUTHORIZATION

2201 Clinch Avenue *AND* **9017 Cross Park Drive, Suite 200**
Knoxville, TN. 37916 **Knoxville, TN. 37923**
Phone (865) 525-0228 **Phone (865) 690-1161**
Fax (865) 525-0285 **Fax (865) 531-8710**

Kurt F. Brandt, MD
Scott W. Brice, MD
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Ronald L. Rimer, MD
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Dennis R. Solomon, MD
Barbara J. Summers, MD
William F. Terry, MD

Stephanie Anderson, RN, CPNP **Ben Batchelor, RN, CPNP** **Amanda Perry, RN, CPNP**

There is a fee of $20 for the first five (5) pages or less of the medical record and a per page charge of 50¢ 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
____Graduated from pediatrics
____Insurance
____Wait times **specify** (waiting room, in room, nurse line, appt line)
____Other________________________________

____Dissatisfied with physician
____Dissatisfied with staff:
____Front office____ Nurse____ Business Office
(comments) ____
____

************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: ________________

revised 4/27/11rps