# KNOXVILLE PEDIATRIC ASSOCIATES, P.C.

## RECORDS RELEASE AUTHORIZATION


**1124 E. Weisgarber Rd. Suite 200** ***AND*** **11416 Grigsby Chapel Rd. Suite 104**

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| **1124 E. Weisgarber Rd. Suite 200** | **11416 Grigsby Chapel Rd. Suite 104** |
| **Knoxville, TN. 37909** | **Knoxville, TN. 37934** |
| **Phone (865) 588-3525** | **Phone (865) 671-2595** |
| **Fax (865) 558-6153** | **Fax (865) 671-2598** |

**Robert L. Barnes, MD**
**Cameron T. Blevins, MD**
**Gurpreet (Tina) Bullen, MD**
**Wayne D. Fogle, MD**
**Lisa M. Herron, MD**
**Donald E. Larmee, MD**
**J. Jeff Lin, MD**
**Lisa B. Padgett, MD**
**Joseph N. Peeden, MD**
**Susan Roberts, MD**
**Susan Scott, MD**
**Gregory L. Swabe, MD**
**Deanna R. Yen, MD**


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¢ a page for all pages thereafter. There is NOT a charge to release records directly to another physician.

**Release records to (name and address):**
_______________________________________________
_______________________________________________
_______________________________________________
Phone____________________Fax________________

**Release records from (name and address):**
_______________________________________________
_______________________________________________
_______________________________________________
Phone_____________________Fax_______________

**Please release records on the following patient:**

**Name**____________________________________________________________ **Date of Birth**____________________

**REASON FOR RECORDS RELEASE**: _______________________________________________________________

**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 RECORDS WILL BE RELEASED AS INITIALED ABOVE.**
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. There is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

**Signature**________________________________________________________**Date**_______________________

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**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 4/27/11 rps