KNOXVILLE PEDIATRIC ASSOCIATES, P.C.

RECORDS RELEASE AUTHORIZATION

2201 Clinch Avenue
Knoxville TN 37916
Phone (865) 525-0228
Fax (865) 525-0285

and

9017 Cross Park Drive, Suite 200
Knoxville TN 37923
Phone (865) 690-1161
Fax (865) 531-8710

Kurt F. Brandt, MD
Ashley F. Gilmer, MD
Dennis R. Solomon, MD
William F. Terry, MD

Scott W. Brice, MD
Kimberly Kim, MD
Philip B. Stanley, DO
Benjamin Batchelor, RN, CPNP

Karen V. Freeman, MD
Ronald L. Rimer, MD
Barbara J. Summers, MD
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, and phone):
_____
_____
_____
_____

Release records from (name, address, and 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 Dept
(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_____

Office Use Only - (Driver's License/photo ID must be presented)

Driver's License/ID number of individual to whom records released: _____
Date records released: _____ Relationship to patient: _____
Amount charged for records: _____ Employee Initials: _____

revised 3/18/14rps