

KNOXVILLE PEDIATRIC ASSOCIATES, P.C.
RECORDS RELEASE AUTHORIZATION

1124 E. Weisgarber Rd., Suite 200
Knoxville, TN 37909
Phone (865) 588-3525
Fax (865) 558-6153

11416 Grigsby Chapel Rd., Suite 104
Knoxville, TN 37934
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Lisa B. Padgett, MD
Gregory L. Swabe, MD

B. Paul Jones, MD
Susan B. Roberts, MD
John W. Wilkinson, MD

There is a \$20 fee for the first five (5) pages or less of the medical record and 50¢ per page for all pages thereafter. There is NOT a charge to release records directly to another physician.

Release records to (name and address):

Release records from (name and address):

Phone _____ Fax _____

Phone _____ Fax _____

Please release records on the following patient(s):

Name _____ Birthdate _____
Name _____ Birthdate _____

REASON FOR RECORDS RELEASE (if moving please provide forwarding home address): _____

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 _____ Relationship to patient _____

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

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

Date records released: _____ Relationship to patient: _____

Amount charged for records: _____ Employee Initials: _____