Medical Records Release Form

Release Records From:

Name:_____

Address:_____

Phone:_____

Fax:_____

By signing this form, I authorize you to release confidential health information about my child by releasing a copy of my child's medical records, or a summary or narrative of my child's protected health information, to the physician/person/facility/entity listed below:

Release Records To:

Kidzcare Pediatrics
119 Epperson St
Athens, TN 37303
Office: 423-745-7500
Fax: 423-745-7501

Kidzcare Pediatrics
4233 Hwy 411, Suite B
Madisonville, TN 37354
Office: 423-545-8383
Fax: 423-545-8387

Kidzcare Pediatrics
2317 S. Roane St
Harriman, TN 37748
Office: 865-285-9721
Fax: 865-590-7298

Patient Name:_____ Date of Birth:_____

The information you may release subject to this signed release for is as follows:

□ Complete Medical Record □ History & Physical □ Progress Notes □ Care Plan □ Lab Reports

□ Radiology Reports □ Hospital Records □ Medication Records □ Immunization Record

□ Other (please specify)_____

The purpose of this release is as follows:_____

I understand that I may revoke this authorization at any time and unless an earlier date is specified; it will automatically expire one year after the date affixed below. Submit your revocation to the Privacy Office of the practice. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and is no longer protected by HIPPA.
My signature indicates that I am authorized to obtain or release records on the above-named patient. There is no court order denying guardianship, parental rights, or authorization to obtain these records.

Signature:_____ Relationship to Patient:_____Date:_____