3328 Jenkins Road
Suite 200
Chattanooga, TN 37421

Phone: (423) 825-4040
Fax: (423) 825-4043

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, _____ hereby authorize (*Old Office*) _____

(*Previous Office's Phone #*) _____ (Previous Office's Fax #) _____

to release the following medical records on my child:

_____ DOB: _____ to Chattanooga Peds.

If there are more than 50 pages total, please mail records to address at the top of the page.

This request and authorization applies to:

__Discharge summary	__Face Sheets	__X-Rays
__History and Physicals	__Procedures	__Consultation Reports
__Inpatient Records	__Outpatient Records	__Immunization Records
__Emergency Room Records	__Office Notes	__All

I understand that the patient's information is protected by HIPAA regulations, and that Chattanooga Peds will not release this information unless given permission by the parent/patient.

_____ _____

Signature of patient (or parent if minor) Date

_____ Parent's Phone Number: _____

Printed name of patient

_____

Name of Staff Member Providing Information

This authorization to release will expire one year from the date of signature.