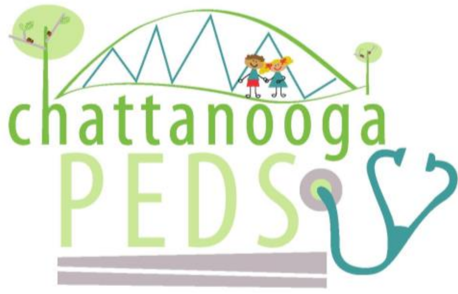

3328 Jenkins Road
Suite 200
Chattanooga, TN 37421

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

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I, ________________________________ hereby authorize Chattanooga Peds to release the following medical records on

my child ____ DOB: __________________________

to (New Office) ____

(New Office's Phone #) _______________________________ (New Office's Fax #) ________________________________.

Reason for leaving: ____

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.