EAST TENNESSEE Children's Hospital

Pediatric Neurology
2100 W. Clinch Avenue
Suite 210
Knoxville, TN 37916
Phone: (865) 523-5437
Fax: (865) 246-7566

Authorization for Release of Information

Patient name: _____ Date of birth: _____

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RELEASE RECORDS TO:

Name of practice or entity: _____

Street address: _____ State/Zip Code: _____

Phone number: _____

Fax number - available for medical practices only _____

By method of ☐ Fax/CD (to medical practices only) ☐ Mail (allow up to 10 days)
There is no charge to release medical records directly to another provider practice.
Cost of supplies and a copy preparation fee is allowable by Tennessee *Code Annotated 63-2-101, 102* will be charged if records are released directly to an individual, attorney, or other third party. This must be paid prior to release of records.
First 20 pages = $20 Pages 21 - 250 = $0.50 per page Pages 251 + = $0.25 per page
Medical Records to disc = $10

I hereby request and authorize _____ to release copies of the above patient (s)' entire medical record, including diagnosis, treatments, prognosis, recommendations, and all other data. I understand that lab; radiology, specialist's reports or any other information from other providers regarding the patient and in our possession may be copied and released.

Reason for request (choose all that apply)

It is our goal to provide quality health care and exceptional service, so your feedback is appreciated.

☐ Moving out of town
☐ Waiting time
☐ Transfer to another provider
☐ Not satisfied with staff:
☐ Front office ☐ Nursing Staff ☐ Billing
☐ Transition to adult care provider
☐ Continuing care/referral
☐ Not satisfied with provider
☐ Insurance change
☐ Legal purposes

I understand that:

- This authorization is valid unless I revoke it in writing.
- Revoking the authorization will not apply to any records released prior to the date I revoke the authorization.
- My refusal to sign this authorization will not affect treatment, payment, enrollment, or eligibility for benefits:

Printed name: _____ Date: _____

Signature: _____ Date: _____

Parent/guardian phone number: _____

Faxed on date (for internal use only): _____

Initial: _____