EAST TENNESSEE Children's Hospital

Sevierville Pediatrics
502 Winfield Dunn Pkwy.
Sevierville, TN 37876
Phone: (865) 453-4434
Fax: (866) 610-2903

Authorization for Release of Information

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

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

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: _____

For internal use only: Faxed on date: _____ Initial _____

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Name of practice or entity: _____

Street address: _____ State and zip code: _____

Fax number - available for Medical Practices Only: _____

I authorize Medical Records for the above patient(s) to be released to (facility)

I hereby give my consent and authorize the person or entity above to release unto (facility) Sevierville Pediatrics medical information on my child/children as requested above.

Please check ONE ✓

☐ ENTIRE CHART **or**

☐ Only the following information: _____

_____

_____

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