EAST TENNESSEE Children's Hospital

Pediatric Neurology
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Suite 210
Knoxville, TN 37916
Phone: (865) 523-5437
Fax: (865) 246-7566

Authorization for Release of Information

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

RELEASE RECORDS FROM:

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) _____ medical information on my child/children as requested above.

Please check ONE ✓

☐ ENTIRE CHART **or**

☐ Only the following information: _____

_____

_____

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: _____