pediatric choice

Authorization for Release of Information

patient name | date of birth | social security number | sex

legal gaurdian's name | relationship

home phone | cell phone

I Authorize Pediatric Choice Clinic to release information:

☐ to ☐ from

Pediatric Choice Clinic
5505 Creekwood Park Blvd.,
Lenoir City, TN 37772
ph 865.986.1400
fx 865.986.9400

☐ to ☐ from

The purpose of the request: ☐ healthcare ☐ insurance coverage ☐ personal ☐ other

Specific information authorized: (check one or more as appropriate)

☐ all ☐ progress notes ☐ laboratory test results ☐ immunization records ☐ physicals
☐ vision and/or hearing screen results ☐ other

One-time Use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire: ☐ when the requested information has been sent/received ☐ 90 days from this date
☐ other

I understand that:

1. **I may cancel this authorization at anytime by submitting a written request to Pediatric Choice Clinic, except where a disclosure has already been made in reliance on my prior authorization.**
2. **If release of records from Pediatric Choice Clinic is for permanent continuation of care from another provider/organization the doctor-patient relationship previously established will end immediately except for emergency care which will continue for the next 30 days. Immunizations/physicals/screening tests will not be provided during this time.**
3. **If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.**
4. **If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.**
5. **If medical record information is to be released there may be a charge of the requested information.**

signature of legal guardian | date

Patient or Representative has been provided a copy of this authorization: staff member providing copy