



Medical Records Release Form

Release Record to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

Release Records From:

Kidzcare Pediatrics

119 Epperson Street

Athens, TN 37303

P: 423-745-7500 F: 423-475-7501

Please release records on the following patient:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for release: \_\_\_\_\_

Expiration or revocation of authorization: I understand that I may revoke this authorization at any time and that unless an earlier date is specified; it will automatically expire 12 months after the date if affixed below. Submit your revocation to the Privacy Office of the Practice. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by HIPPA.

My signature below indicates that I am authorized to obtain or release records on the above named patients. There is no court order denying guardianship, parental rights or authorization to obtain or release these records.

Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_