Spring Creek Pediatrics

929 Spring Creek Rd. Ste 206
Chattanooga, TN 37412
Telephone: (423) 892-3400 Fax: (423) 892-8266

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

ADDRESS: _____

DOB: _____ **PHONE:** _____

REQUEST RELEASE FROM:

NAME: _____

ADDRESS: _____

CITY: _____

STATE, ZIP: _____

PHONE: _____

FAX: _____

REQUEST RELEASE TO:

NAME: _____

ADDRESS: _____

CITY: _____

STATE, ZIP: _____

PHONE: _____

FAX: _____

I, _____, authorize _____
PATIENT/GUARDIAN NAME PERSON/FACILITY

to release my medical records as specified below: **PLEASE CHECK ALL THAT APPLY**

__ **All**
__ Reports of tests/x-rays
__ Inpatient Records
__ Discharge Summary
__ ER records
__ Outpatient Records
__ Consult Reports
__ Office Notes
__ History & Physical
__ Other _____

REASON OR PURPOSE FOR THE USE AND/OR DISCLOSURE OF THIS INFORMATION:

Moved Change of Insurance Change of Doctors

Other _____

_____ _____
SIGNATURE OF PATIENT (OR PARENT IF MINOR) DATE

_____ _____
PRINTED NAME RELATIONSHIP TO PATIENT