# Spring Creek Pediatrics

Release Of Medical Records

Release To ____ Release From____ Release to Parent___

929 Spring Creek Road Suite 206
Chattanooga, Tn 37412
Phone: (423)892-3400
Medical Records Fax: (423)648-2692

Patient Name_____ DOB_____
Address_____

Doctor records are to be released from or to (if releasing from SCP)
Name: _____
Address :_____
Phone & Fax Number:_____

The following protected health information may be used and/or disclosed.
Check all that apply.

Dates of Treatment to be released: **All** or _____ to _____

___ **All**
___ Discharge Summary
___ Face Sheets
___ Procedures
___ History & Physical
___ Reports of tests & x-rays
___ Emergency Room records
___ Consultation Reports
___ Immunization Records
___ Inpatient Records
___ Outpatient Records
___ Office Notes

___ 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

_____ _____
Name of Staff Member Releasing Records Date Released