AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION TO:

PEERLESS PEDIATRICS

Physician/Facility to provide records: _____
Address: _____
_____
Phone: _____
Fax: _____
Patient's Name: _____
Address: _____
_____
Phone: _____
DOB: _____
SS#: _____

PLEASE SEND MY RECORDS TO:

- ☐ Dennis Betts, MD
- ☐ Brian Coyle, MD
- ☐ Barry Crabtree, MD
- ☐ Wayne Kelly, MD
- ☐ Stephanie Sanderson, MD

Peerless Pediatrics
1060 Peerless Crossing, Suite 100
Cleveland, TN 37312
Phone: (423) 339-5656
Fax: (423) 339-8889

RELEASE THESE RECORDS: INITIALS

1. The entire chart _____
2. Only records generated by this facility (not including records received from other sources) _____
3. Only some portions of records maintained at this facility (dates of treatment, etc., please specify below) _____

_____

I authorize **PEERLESS PEDIATRICS** to release the information specified to the above-named with the **EXCEPTION** of:

INITIALS

_____ Substance abuse, if any
_____ Psychological or psychiatric conditions, if any
_____ HIV/AIDS, if any
_____ Other (please specify): _____

REASON FOR RECORD REQUEST:

- ☐ Changing Physicians
- ☐ Other:

I understand that I may revoke this authoriz ime, and that unless an earlier date is specified, it will automatically expire in 12 months from the date signed.

Patient's Name (Print): _____
Patient's Signature: _____
Date: _____

OR

Person authorized to sign for patient: _____
Relationship to patient: _____
Patient's Signature: _____
Date: _____