PEERLESS PEDIATRICS

AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION TO:

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

Patient's Name: ______________________________
Address: ______________________________
____
Phone: ______________
DOB: ______________
SS#: ______________

PLEASE SEND MY RECORDS TO: ______________________________
Address: ______________________________
____
Phone: ______________
Fax: ______________

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
- ☐ Change of Insurance Plans
- ☐ Age (pediatrics to adult physician)
- ☐ 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): ____________________ OR Person authorized to sign for patient: ____________________
Patient's Signature: ____________________ Relationship to patient: ____________________
Date: ____________________ Patient's Signature: ____________________
Date: ____________________