



Developmental Behavioral Center
 2100 Clinch Koppel Plaza, Suite 410
 Knoxville, TN 37916
 Phone: 865.343.6976
 Fax: 877.926.0521

Authorization for Release of Information

Patient name: _____ Date of birth: _____

Patient name: _____ Date of birth: _____

RELEASE RECORDS TO:

Name of practice or entity: _____

Street address: _____ State/Zip Code: _____

Phone number: _____

Fax number - available for medical practices only _____

By method of Fax/CD (to medical practices only) Mail (allow up to 10 days)

There is no charge to release medical records directly to another provider practice.

Cost of supplies and a copy preparation fee is allowable by Tennessee Code Annotated 63-2-101, 102 will be charged if records are released directly to an individual, attorney, or other third party. This must be paid prior to release of records.

First 20 pages = \$20 Pages 21 - 250 = \$0.50 per page Pages 251 + = \$0.25 per page

Medical Records to disc = \$10

I hereby request and authorize _____ to release copies of the above patient (s)' entire medical record, including diagnosis, treatments, prognosis, recommendations, and all other data. I understand that lab; radiology, specialist's reports or any other information from other providers regarding the patient and in our possession may be copied and released.

Reason for request (choose all that apply)

It is our goal to provide quality health care and exceptional service, so your feedback is appreciated.

- | | | |
|---|--|---|
| <input type="checkbox"/> Moving out of town | <input type="checkbox"/> Transition to adult care provider | <input type="checkbox"/> Insurance change |
| <input type="checkbox"/> Waiting time | <input type="checkbox"/> Continuing care/referral | <input type="checkbox"/> Legal purposes |
| <input type="checkbox"/> Transfer to another provider | <input type="checkbox"/> Not satisfied with provider | |
| <input type="checkbox"/> Not satisfied with staff: ___ Front office ___ Nursing Staff ___ Billing | | |

I understand that:

- This authorization is valid unless I revoke it in writing.
- Revoking the authorization will not apply to any records released prior to the date I revoke the authorization.
- My refusal to sign this authorization will not affect treatment, payment, enrollment, or eligibility for benefits:

Printed name: _____ Date: _____

Signature: _____ Date: _____

Parent/guardian phone number: _____

For internal use only: Faxed on date: _____ Initial _____