West Knoxville Pediatrics
224 S. Peters Road, Suite 105
Knoxville, TN 37923
p. 865.470.8844
f. 866.479.4403

Authorization for Release of Information

Patient name: ______________________ Date of birth: ____________

Patient name: ______________________ Date of birth: ____________

RELEASE RECORDS FROM:

Name of practice or entity: ______________________

Street address: ______________________ State and ZIP code: ____________

Fax number - available for Medical Practices Only: ______________________

I authorize Medical Records for the above patient(s) to be released to (facility)

I hereby give my consent and authorize the person or entity above to release unto (facility) ______________________ medical information on my child/children as requested above.

Please check ONE ✓

☐ ENTIRE CHART **or**

☐ Only the following information: ______________________

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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: ____________