



Sevierville Pediatrics
1115 Blanton Drive
Sevierville, TN 37862
Phone: (865) 453-4434
Fax: (865) 428-3508

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: _____

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: _____