



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: _____

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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: _____