EAST TENNESSEE Children's Hospital

For questions, please call (865) _____.
Please fax completed form to (865) _____.

Authorization for Release of Information

I do hereby give my consent to and authorize _____
(name of organization)

to release unto East Tennessee Children's Hospital medical information on _____
(patient's name)

(Patient's date of birth: _____) who was treated by you. This information will be used for the following purpose: _____.

The following information is requested:_____

_____

_____

_____

_____

I understand that:
- This authorization is valid unless or until 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.

Print name:_____Date: _____

Signature: _____
(parent, patient or other authorized party)

Relationship to patient:_____

_____
Witness

2018 Clinch Avenue
Knoxville, TN 37916
www.etch.com
p. 865.541.8000

Form No. 30399 (06/18)