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Patient's Name: ____ DOB: ________________________

Current Address of PT: ____ SS#: _______-______-__________

By signing this AUTHORIZATION, I AUTHORIZE____
(NAME OF PREVIOUS PRACTICE/PHYSICIAN*NEW BORNS BIRTH PLACE)**

ADDRESS:____

CITY:____ STATE: _______ ZIP CODE: ___________________

TELEPHONE #. _____________________________________ FAX #: ____

INFORMATION REQUESTED:
____IMMUNIZATION RECORDS
___HOSPITAL RECORDS
___OFFICE NOTES
___ WELL EXAMS
___ X-RAYS / LABS
___ OTHER ____

PURPOSE OF RELEASE:______________________________
___ SELF
___ CONTINUATION OF CARE
___ ATTORNEY REQUEST
___ SPECIALIST REFERRAL

TO THE FOLLOWING PRACTICE/PHYSICIAN: GRACE PEDIATRICS, PLLC ____

__1335 Rock Springs Road, Suite 100 , Smyrna, TN 37167 Phone: 615.459.5252 Fax: 615.459.5232

__238 Centre Street, Suite 100, Pleasant View, TN 37146 Phone: 615.746.4040 Fax: 615.746.4044

__990 Elliston Way, Suite 100, Thompson's Station, TN 37179 Phone: 615-550-5221 Fax: 615-550-5226

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The purpose of this request is at "THE PARENT / GUARDIAN REQUEST ", unless stated otherwise. The purpose is provided so that you can make an informed decision whether to allow release of the information. The authorization will expire ninety days from the date of signature below. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken.

I understand that information in my Health Records may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency (HIV) and other communicable disease, Behavioral Health Care and treatment related to drug or alcohol use: my signature authorizes the release of such information.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part2.

I understand that GRACE PEDIATRICS hasn't any control how the recipient uses or shares the information, and that laws protecting its confidentiality at GRACE PEDIATRICS may or may not protect this information once it has been disclosed to the recipient.

____ ____
SIGNATURE OF PATIENT(IF 18,PARENT / GUARDIAN **PRINTED NAME** **DATE**

____ ____
SIGNATURE OF WITNESS **PRINTED NAME** **DATE**

P:Forms/MedicalRecordsReleaseGRACE/3.2016