BRENTWOOD PEDIATRIC CARE

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Address: _____ Phone_____

Records to be released from:

Name of Health Care Provider/Facility: _____

Fax #: _____ Phone: _____

Address: _____

Records to be released to:

Brentwood Pediatric Care
343 Franklin Rd Suite 106 **Fax #: 615-814-4501**
Brentwood, TN 37027 **Phone #: 615-814-4500**

INFORMATION TO BE RELEASED:

_____(initial) I authorize the release of all of my medical records and understand that it may include treatment for mental health, social services, test or treatment for HIV/AIDs or STIs.

Specify if only certain records needed: ___ Immunization Records only ___ Immunization Records with Growth chart only ___ All records ____Other _____

Purpose for need of disclosure (check one):

___ Further Medical Care ____ Insurance/Eligibility ____ Other, Specify_____

I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Brentwood Pediatric Care will not be able to release records to someone else without a signed authorization. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization

_____ _____

Name (print) Parent/Guardian/Patient (over 18) Relationship to Patient

_____ _____

Signature Parent/Guardian/Patient (over 18) Date

Rev 2/3/22