Authorization for Release of Confidential Medical Information

Complete the following Information:

Father's Name: _____ Mother's Name: _____

Address: _____

City _____ State: _____ Zip: _____ Phone: _____

List patient(s) including the Date of Birth

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Requesting Records From: **(physician name and address)**

_____

_____

_____

Send Records To: **(physician name and address)**

_____

_____

_____

Requesting Records from another practice please forward records to:

Brentwood Children's Clinic
95 Seaboard Lane, Ste 201
Brentwood, TN 37027
P: 615-261-1210 F: 615-261-1222

Purpose for release:

___Moving out of State
___ Switching Clinics
___ Patient Age
___ Change in Insurance
___Other (please specify)

_____

First set medical records on CD	**No Charge**	
Second CD	**$15.00**	_____
Medical records on paper	**$30.00**	_____
Medical records requested from offsite storage	**$15.00**	_____

I authorized Brentwood Children's Clinic to release all Medical Records for the patients listed above for whom I am the parent or legal guardian. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information. *Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

_____ _____

Signature of Parent/Guardian or Patient if over 18 yrs Old Date

_____ _____

Print Name Parent/Guardian or Patient if over 18 yrs Old Date