Chart Number: _____
PCP Initials: _____

Plateau Pediatrics
3234 Miller Ave
Crossville, TN 38555
(931) 707-8700
Fax: (931) 456-0802

Release of Records Authorization: Medical Edition

To: Medical Records Administrator

Provider/Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____City: _____State:_____ Zip_____

Patient name: _____ Date of Birth: _____

Dates of Care: _____ to _____

Purpose for release: ☐ Continuity of Care ☐ Transferring Care ☐ Other: _____

Authorization is hereby granted to you to release to Plateau Pediatrics, PLC

The following information for the approximate date(s) of care listed above:

- ☐ Immunization records
- ☐ Progress notes
- ☐ History and physicals
- ☐ Consultation reports
- ☐ Health history
- ☐ Lab and study results
- ☐ Discharge summaries
- ☐ Operative reports
- ☐ PT, OT, speech therapy evaluations
- ☐ Physician's order sheets
- ☐ Medications administered
- ☐ Other: _____

I specifically authorize the provider/facility listed above to release the following items:

- ☐ Mental Health Records
- ☐ Developmental Disabilities diagnosis and treatment
- ☐ Alcohol and Drug Abuse treatment
- ☐ HIV and AIDS diagnosis and treatment

Signature of patient for above 4 items (if 16 or over): _____

This authorization shall automatically expire 90 days, unless otherwise specified, after the date of signature and covers only information prior to that date. I understand that I may withdraw this consent at any time, but the revocation shall not be retroactive to the release of information made in good faith. I may revoke this authorization by submitting a request, in writing, to the Privacy Office, 3234 Miller Avenue, Crossville, TN 38555. When the information is used or disclosed with this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I understand that this information may include, but not limited to, information related to psychiatric or psychological treatment, treatment for drug and/or alcohol use, or information relating to AIDS/HIV. I understand that I have the right to refuse to sign this form and that my refusal will not result in the provider refusing to provide care.

Signed: _____ Date:_____

Printed Name: _____ Expiration Date: _____

Relationship to patient: _____

Witness: _____ for Plateau Pediatrics, PLC