LOUDON PEDIATRIC CLINIC, P.C.
616 Ward Avenue
Loudon, TN 37774
Phone # 865-458-5666 Fax# 865-458-9906

Authorization for Release of Medical Information

____
(Patient Name)

______________________ ______________________
(Date of Birth) **(Social Security #)**

____
Street **City** **State** **Zip** **Phone #**

______________________ ______________________
(Legal Guardian) **(Relationship)**

I hereby authorize Loudon Pediatric Clinic, P.C.
To release information

___To: ___From:

Loudon Pediatric Clinic, P.C.
616 Ward Avenue
Loudon, TN 37774
Phone # 865-458-5666
Fax # 865-458-9906

(Please provide phone or fax number)
___To: ___From:

____
____
____
____
____

Purpose of Request:
__Healthcare ___Insurance Coverage ___Moving ___Personal ___Other

Specific Information Authorized: (Select one or more as appropriate)
___All ___ Laboratory Reports ___Physicals
___Immunization Records ___X-Ray Reports ___Vision and/or Hearing Reports
___Other (specify)____

I Understand That:

1. This authorization shall be in force and effect until ______________________ at which time this authorization to use or disclose this protected health information expires. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date of signing.
2. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at 616 Ward Avenue, Loudon, TN 37774. I understand that a revocation is not effective to the extent that my physician has relied on the use of disclosure of this protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
3. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
4. If release of records from Loudon Pediatric Clinic, P.C. is for permanent continuation of care from another provider/organization, the doctor-patient relationship previously established will end immediately except for emergency care which will continue for the next 30 days. Immunizations, physicals, screening tests will not be provided during this time.
5. If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
6. I consent to the use of a fax machine to transmit any or all of my above described medical records either to or from Loudon Pediatric Clinic, P.C. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of my medical records to unauthorized parties. I hereby release the medical care provider faxing the records from Loudon Pediatric Clinic, P.C. from all legal responsibility for liability that may arise from the act I have authorized herein. The sender of the medical records will not be responsible for the completeness, legibility or omittance caused by the copying and/or faxing of any of the above medical records (including my records from Loudon Pediatric Clinic, P.C. or from another institution which may be in the Loudon Pediatric Clinic, P.C. chart).
7. If the medical record information is not sent to another care provider, there may be a charge of the requested records.

_______________________________ _______________________________

Signature of Legal Guardian **Date**

SPECIFIC AUTHORIZATION

I acknowledge that data to be released may include material that is applicable to mental health, developmental disabilities, alcohol or drug abuse, and/or sexually transmitted disease information. My signature authorizes release of all such information (as specified above). If I refuse to sign this authorization, those in possession of my medical records will not release them absent of a court order.

_______________________________ _______________________________

Signature **Witness**

____

Date