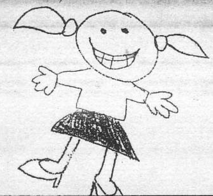


Cleveland Pediatrics P.C.

Authorization for Release of Protected Health Information

435 25 ST N.W.
Cleveland, TN 37311
Phone (423) 479-9733 FAX (423) 4721890

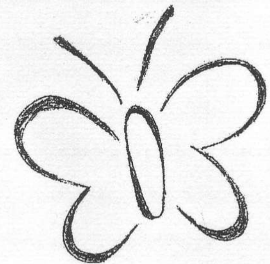
Please mail if more than 10 pages!

Patient's Name____________________ Date of Birth ____/____/______

Parent's Name ____________________ Phone Number ________________

______ I authorize Cleveland Pediatrics P.C. to ***release*** records to the following facility:

______ I authorize Cleveland Pediatrics P.C. to ***request*** records from the following facility:



Name of Physician's Office: ______________________________
(Complete name of previous doctor's office please)

Address: ____

City: ____________________ State ____________ Zip _____

Phone ( ) ______________ Fax ( ) __________ Doctor's Name ____________

Purpose of release: ____ Changing Doctor ____ Moved _____ Emer. Treatment

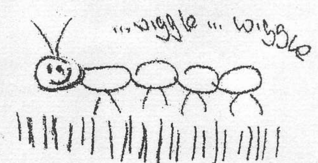
____ Doctor changed Locations

Records to release: ____ Entire Chart ____ Immunizations ____ Immunizations only ____ Other

____ Lab results ____ Hosp. Records ____ Consult Letters

Dates: From: __________ To __________

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that you have acted upon this authorization.



_________________________ _________________________
Printed Name of Parent/Guardian Signature of Guardian/Guardian

________________ _________________________
Date Witness