

Tullahoma Pediatrics, PLLC
Manchester Pediatrics
Royal Pediatrics
Mailing address: PO Box 1327
Tullahoma, TN 37388
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Records Release Authorization

Please release records on the following patient:

Patient's Name: _____ DOB: _____
(Please use a separate authorization for each child)

The charge to release records is a fee of \$5.00 for 1-5 pages, or \$10.00 for 6-10 pages, or \$20.00 which shall include the first forty (40) pages of the medical record and twenty-five cents (.25c) per page for all pages thereafter, plus the actual cost of mailing. A summary report provided directly to another Pediatrician will not incur a charge.

Information below must be completed for PHYSICIAN or ORGANIZATION	*Release records To _____ or From _____
Name:	Tullahoma Pediatrics, PLLC
Address:	PO Box 1327
City, State:	Tullahoma, TN 37388
Tel:	Telephone: (931) 455-2674
Fax:	Fax: (931) 455-8983

Please choose a reason for the records release:

- | | |
|---|--|
| <input type="checkbox"/> Changing Primary Care Provider | <input type="checkbox"/> Evaluation and management of behavioral or developmental health |
| <input type="checkbox"/> Applying for services, benefits, program | <input type="checkbox"/> Coordination of care or services |
| <input type="checkbox"/> Other please list: _____ | |

I authorize the health care provider to release any and all information specified to the organization, agency, or individual named on this request as follows:

Medical Records (does not include Psychological records)

- Medical Record Summary (No Charge)
- Individual office visits (Usually extensive, see charges listed above)
- Well Child Exams & Immunization Record (No Charge)
- Labs/Xrays/Reports from referred health care providers
- Previous medical records
- Medical and Social history

Behavioral Health Records

- Medical & social history
- Diagnostic testing results and Diagnoses
- Treatment Plan, Medication List, Progress Notes
- Mental health treatment records from other providers
- Substance Abuse
- AIDS/HIV records

Release of information is further restricted / released as noted below:

- Please include only the specified records from the dates of _____ through _____.
- Please allow *two-way communication* regarding the specified records, both written and verbal, between the two parties designated above.

This authorization will automatically expire in 12 months from the date I sign below unless an earlier date is specified. I understand that I may revoke this authorization at any time by notifying this office in writing. Tullahoma/Manchester/Royal Pediatrics will not condition any provision of treatment on my signing the authorization. Once the protected health information is disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. I am entitled to a copy of this authorization.

My signature below indicates that I am authorized to obtain/release records on the patient indicated, and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records. This authorization is given voluntarily without coercion.

Signature: _____ Date: _____

Name of individual signing the release: _____ Driver License/ID # of individual: _____

Individuals relationship to the patient: _____ Witness Signature: _____ Amount charged \$ _____