Tullahoma Pediatrics, PLLC
Manchester Pediatrics
Royal Pediatrics
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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:

_____ Changing Primary Care Provider
_____ Evaluation and management of behavioral or developmental health
_____ Applying for services, benefits, program
_____ Coordination of care or services
_____ 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 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. 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 $ _____