siskin children's institute CENTER FOR DEVELOPMENTAL PEDIATRICS

A pediatric practice affiliated with The University of Tennessee College of Medicine Chattanooga, Department of Pediatrics and with Children's Hospital at Erlanger.

THE UNIVERSITY of TENNESSEE COLLEGE of MEDICINE CHATTANOOGA

children's Hospital at Erlanger

AUTHORIZATION TO RELEASE INFORMATION – General & School Consent

(Must complete all fields for document to be processed)

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone #: _____

City/State/ZIP: _____ Medical Record #: _____

Release Information FROM Siskin	Release of Information TO Siskin
I authorize the below listed Physician (Phy.), Institution (Inst.), or School (Sch.) to release and/or obtain information requested on this form to Siskin Children's Institute. ☐ Release ☐ Obtain **The information should be sent from:** Phy., Inst., or Sch.: _____ Address: _____ City/State/Zip: _____ Phone # _____ Fax #: _____ Please note that the information disclosed to this authorization may be subject to re-disclosure by the recipient and no longer protected by Siskin.	☐ I authorize Siskin Children's Institute to verbally speak to the listed Physician, Institute, or School listed to the left: Please send information requested to: **Siskin Center for Developmental Pediatrics** **1101 Carter Street Chattanooga, TN 37402** **P: (423) 490-7710 F: (423) 490-7750**
	Dates of Treatment (Dates of treatment you need records for) Dates: _____ The information that is to be released should be detailed to specific dates of service, treatment, etc.

Information to be Released		Purpose of Release	
☐Clinic Visits	☐Labs	☐Ongoing Care with SCDP	☐Insurance
☐Psychological Records	☐X-Ray/Img	☐Cont. Care	☐Deposition
☐OT Therapy Records	☐IEP	☐Billing	☐Attorney
☐PT Therapy Records	☐Other: (list)	☐Work Comp	☐Other (list)
☐ST Therapy Records	_____	☐Social Sec.	_____
☐Medication Information	_____	☐Disability	_____

If you DO NOT WANT certain portions of your medical records released, please initial for the information:

Substance Abuse: _____ Psychological or Psychiatric Treatment: _____ HIV/AIDS/STD: _____

I understand I have the right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carrier with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits may not be a condition to obtain this authorization.

This authorization is for school year ____/____ or expires_____(date).
Note: This form will automatically expire in 365 days from signature date below.

Signature of patient, parent, or legal guardian	Print Name/ Relationship to child	Date