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.

AUTHORIZATION TO OBTAIN INFORMATION - MEDICAL RECORD REQUEST

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone#: _____

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

Information is being requested by:

☐ Parent/Legal Guardian ☐ Therapist: _____ ☐ Provider/Nurse: _____ ☐ Other: _____

I authorize Siskin Center for Developmental Pediatrics to **OBTAIN** information from

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Information to be **OBTAINED:**

☐ Clinic/Office Visits

Dates of Treatment: _____

☐ Psychological Records

Dates of Treatment: _____

☐ OT Therapy Records

Dates of Treatment: _____

☐ ST Therapy Records

Dates of Treatment: _____

☐ IEP

School Year: _____

☐ Other (specify) _____

Dates of Treatment: _____

Purpose of Obtaining Record

☐ Continuation of care

☐ Billing/Insurance Authorization

☐ Other (specify): _____

I understand I have the right to revoke this authorization by written notification to the Medical Records, 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 year _____/_____ or expires _____(date)

Note: This form will automatically expire in 365 from signature date below.

_____ _____ _____

Signature of parent or legal guardian Print Name/Relationship Date