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 RELEASE INFORMATION – MEDICAL RECORD RELEASE

Patient's Name: _____ Date of Birth: _____

Patient's Address: _____ Phone#: _____

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

I authorize **RELEASE** of information FROM
Siskin Center for Developmental Pediatrics
1101 Carter Street Chattanooga, TN 37402
P: (423) 490-7710 **F: (423)-490-7750**

Name:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax:_____

Information to be **RELEASED:**

☐ Medical Visit Notes
Dates of Treatment: _____

☐ Occupational Therapy Records
Dates of Treatment: _____

☐ Speech Therapy Records
Dates of Treatment: _____

☐ Feeding Therapy Records
Dates of Treatment: _____

☐ ABA Therapy Records
Dates of Treatment: _____

☐ Other (specify) _____
Dates of Treatment: _____

Purpose of Release

☐ Continuation of care
☐ Billing
☐ Work Comp
☐ Social Security
☐ Legal Proceedings
☐ Insurance
☐ Disability
☐ 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