AUTHORIZATION TO RELEASE MEDICAL RECORDS/INFORMATION

Kim Breeden MD
Covenant Pediatrics
421 Old Riceville Rd. Ste 2
Athens, TN 37303

Phone: 423-744-8755
Fax: 423-744-8568

PLEASE FAX RECORDS IF POSSIBLE

Office use
☐ Faxed
☐ Mailed
Date: _____

☐ Send records to ☐ Receive records from

Physician/facility: _____

_____

_____

Fax: _____

Patient's Name	DOB	SS#
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IF YOU DO NOT WANT CERTAIN PORTIONS OF YOUR MEDICAL RECORD RELEASED, PLEASE INDICATE BY INITIALING BELOW NEXT TO THE INFORMATION YOU DO NOT WANT RELEASED. OTHERWISE YOUR RECORDS WILL BE RELEASED AS SPECIFIED.

I authorize _____ to release the medical information specified to the above named with the EXCEPTION of:

____ Substance abuse, if any ____ AIDS/HIV, if any

____ Psychological or psychiatric conditions, if any ____ Other _____

REASON FOR RECORDS REQUEST:

☐ Changing Physician ☐ Change of insurance ☐ Age (to adult MD)
☐ Relocation ☐ Other _____

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months from the date signed.

Person authorized to sign for patient _____ Date _____

Relationship to patient _____