KIDS KARE
PEDIATRICS & PEDIATRIC CARDIOLOGY

Authorization to Release Medical Records / Information

Patient's Name: _____ **DOB:** _____

Release Records from: _____

_____

PLEASE MAIL, FAX OR EMAIL MEDICAL RECORDS TO:

Kids Kare Pediatrics and Pediatric Cardiology
758 South Willow Ave.
Cookeville, TN 38501
Phone: (931) 526-6173 Fax: (931) 526-5084
Email: kidskare@kidskare.biz

Please release the selected records:

1. Records generated by this facility ONLY (excluding records from other sources) ☐
2. ONLY Portions of Records maintained at this facility (specify dates or illnesses below) ☐
   _____
3. All medical records at this facility ☐

Please provide reason for authorization: _____

If this authorization is for the purpose of transferring the care of your child(ren) and medical records to another Primary Care provider, please understand that there will be a moratorium of 1 year if you decide to return to our practice in the near future, unless it is for the following reasons: 1) Moving to another state 2) Moving to another location more than 1 hour away 3) To see a specialist 4) to submit records to the school or health Dept. 5) All other reasons other than transfer of care.

PLEASE SIGN AND DATE TO INDICATE YOU UNDERSTAND ABOVE CONDITIONS:

_____	_____	_____
Parent's or Guardian's name	Parent's or Guardian's signature	Date:

If there are certain portions of your medical records you do not want to release, please read this section carefully and check the box(es) next to the records **you do not want released.** They will be excluded from the selected records above.

- ☐ Substance abuse, if any
- ☐ Psychological conditions, if any
- ☐ AIDS / HIV, if any
- ☐ Others (please specify) _____

Expiration of authorization: _____

Revocation of authorization: I understand that I may revoke this authorization at any time before the transfer. is completed.

_____	_____
Parent's or Guardian's name	Today's date
_____	_____
Parent's or Guardian's signature	Relationship to patient