

## Hamblen Pediatric Associates, Inc

- |  |   |
|--|---|
| <input type="checkbox"/> <b>1817 West Morris Blvd<br/>Morristown, TN 37813<br/>Telephone: 423-581-3904<br/>Fax: 423-581-6120</b> | <input type="checkbox"/> <b>1405 S Sizer Street, Suite E<br/>Jefferson City, TN 37760<br/>Telephone: 865-475-5377<br/>Fax: 865-475-3857</b> |
|--|---|

Date of Request: \_\_\_\_\_

Records Being Requested From:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

or:        **HPA – Morristown**                          **HPA – Jefferson City**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I request that the above named patients' medical records be released to:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>1817 West Morris Blvd<br/>Morristown, TN 37813<br/>Telephone: 423-581-3904<br/>Fax: 423-581-6120</b> | <input type="checkbox"/> <b>1405 S Sizer Street Suite E<br/>Jefferson City, TN 37760<br/>Telephone: 865-475-5377<br/>Fax: 865-475-3857</b> |
|--|--|

Or: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I allow the following information to be released: PLEASE CHECK ONE OF THE BOXES BELOW:

- |  |  |
|--|--|
| <input type="checkbox"/> <b>Entire medical record</b>    | <input type="checkbox"/> <b>Progress notes from _____ to _____</b> |
| <input type="checkbox"/> <b>Lab work dated _____</b>     | <input type="checkbox"/> <b>Psychotherapy notes to be released</b> |
| <input type="checkbox"/> <b>Immunization Record only</b> | <input type="checkbox"/> <b>Other: _____</b>                       |

I understand that this consent is good for 1 year and may be revoked at any time by written notice to Hamblen Pediatric. This request is for the following reason.

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Insurance Change – New physician</b>      | <input type="checkbox"/> <b>Relocation</b>      |
| <input type="checkbox"/> <b>Specialty Consult (i.e. ENT, Surgeon)</b> | <input type="checkbox"/> <b>Dissatisfaction</b> |
| <input type="checkbox"/> <b>Exchange of information with School</b>   | <input type="checkbox"/> <b>Personal Use</b>    |
| <input type="checkbox"/> <b>Other: _____</b>                          |   |

I understand that once the requested information is sent that additional disclosures may occur and Hamblen Pediatric will be held harmless for further disclosures by/to other parties.

Patient/Guardian Signature \_\_\_\_\_

Relationship: \_\_\_\_\_ Date \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_