Authorization for Release of Medical Records

I hereby authorize Internal Medicine & Pediatric Associates to obtain protected health information from:

_____

Current Doctor or Practice

_____

Address & Phone/Fax Number

Please release these records to:

_____

New Doctor's Name

Internal Medicine & Pediatric Associates 350 Steeles Rd Ste #2 Bristol, TN 37620

This authorization permits Internal Medicine & Pediatric Associates to acquire the following certain protected health information:

1.____copy of complete health records

2.____radiology reports

3.____laboratory reports

4.____consultation reports

5.____other_____

This information will be used for the purpose of continuation of medical care. This authorization will not expire unless otherwise specified.

_____ _____

Patient's Name (please print) Date of Birth

_____ _____

Patient's Signature (or guardian's) Relationship to Patient

_____

Date Signed

I have the right to revoke this authorization by submitting my written request to the Privacy Officer at the address below.