Sewanee Pediatrics and Adolescent Medicine

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HIPAA Release Form

Name:_____ Date of Birth:_____

Release of Information

_____ Initials: I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be release to:

Name and Relation: _____

Name and Relation: _____

Name and Relation: _____

___ Initials: Information is not to be release to anyone except parents/guardian

NOTE: Parents can get copies of any records, unless we have court documents stating otherwise.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call: my home _____ my work _____ my cell phone _____

If unable to reach me: (check one)

- ☐ You may leave a detailed message
- ☐ Please leave a message asking me to return your call
- ☐ Other_____

*(We will not leave a message if your voicemail does not identify you.)

The best time to reach me (day) _____ other (time)_____

Signed_____ Date_____

Witness: _____ Date_____

***Must complete one for each child's record**