COOKEVILLE PEDIATRIC ASSOCIATES
150 NORTH WILLOW AVENUE
COOKEVILLE, TN 38501
PHONE (931) 528-1485
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to redisclosure and no longer protected by the federal privacy regulations.

- PATIENT NAME:_____DOB_____SSN_____
- INFORMATION SENT FROM: INFORMATION SENT TO:

_____ _____

_____ _____

_____ _____

- INFORMATION TO BE RELEASED: (please specify one)

1.ALL RECORDS GENERATED BY THIS FACILITY: _____
Are there any portions of your record in which you do not want released: Psychological _____, Substance abuse_____, AIDS/HIV_____, Other_____. (Please specify)

2.A PORTION OF RECORDS (specify dates or illnesses) : _____

_____

_____

3.ONLY IMMUNIZATION RECORD: _____

- PURPOSE OF THE USE OR DISCLOSURE: _____

_____

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions: 1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research-related treatment. 2. Refusal to sign this authorization, if it is for the disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

- Parent's initials _____

A copy of this form will be provided if requested.
Cookeville Pediatrics will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
Expiration or revocation of authorization---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 after the date affixed below:

- Parent's Name (please print) _____
- Parent's Signature_____
- Relationship to patient _____Date_____