East Nashville Pediatrics

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name(s) and Date(s) of birth (please provide information for all children for whom records are needed from a single facility)

_____

_____

_____

I, _____, hereby authorize the release of medical information to:

East Nashville Pediatrics
3926 Gallatin Pike, Suite B
Nashville, TN 37216
Phone: (615) 882-4900
Fax: (855) 618-2499

From:
Doctor/Hospital from whom records are being released (this is usually your previous pediatrician's office or your child's birth hospital):

_____

Address:

_____

_____

Phone: _____ Fax: _____

Please release the following records:

- ☐ ALL HEALTH INFORMATION (immunizations, growth curves, problem list, medication list, notes)
- ☐ RADIOLOGY IMAGES
- ☐ LAB RESULTS
- ☐ CONSULTS

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____