Blackmon pediatrics

FORM #: FRM-0001
IMPLEMENTATION: 06.14.2024
UPDATED: 06.14.2024

MEDICAL RECORDS RELEASE | INCOMING

PATIENT NAME:_____ **DATE OF BIRTH:**_____/_____/_____

TO BE OBTAINED FROM:

_____
PROVIDER NAME | PRACTICE NAME

_____
PROVIDER | PRACTICE ADDRESS

(_____)_____-_____ (_____)_____-_____
TELEPHONE NUMBER FAX NUMBER

CONSENT | AUTHORIZATION:

"I do hereby consent and authorize Blackmon Pediatrics, PLLC to obtain copies of my medical records from the provider/practice outlined above. I further agree that a copy of this release and/or a fax of this release shall be deemed to be as valid as this original."

MEDICAL RECORDS DATE RANGE: _____/_____/_____ THRU _____/_____/_____
BEGINNING DATE OF SERVICE ENDING DATE OF SERVICE

☐ All Medical Records: to include but not limited to current & previous medical records from Blackmon Pediatrics and other providers/practices, hospitals, clinics, diagnostic services, laboratories, alcohol/drug treatment, mental health information, and HIV/STD related information which are included in this medical record."

☐ All Medical Records except the following: _____

_____

☐ Include the following Medical Records only: _____

_____

REQUESTOR SIGNATURE: _____ **DATE:** _____/_____/_____

REQUESTOR NAME: _____
PLEASE PRINT

REQUESTOR'S RELATIONSHIP TO PATIENT:

☐ PATIENT (Age 18+ or Emancipated Minor) ☐ PARENT

☐ OTHER _____ ☐ LEGAL GUARDIAN

7714 Conner Road, Suite 101 • Powell, Tennessee 37849
Phone: (865) 212-6350 • Fax: (865) 212-6446