

Pediatric Associates of Franklin

570 Bakers Bridge Avenue, Franklin, TN 37067

AUTHORIZATION FORM: RELEASE OF **SPECIFIC ITEMS** FROM THE MEDICAL RECORD

As parent or legal guardian of the following child, I hereby authorize Pediatric Associates of Franklin to release to me the following information from my child's medical record. I authorize that this specific information be released regarding my child's physical or mental condition. I also understand that this release is only for the items mentioned on this form and that the release is valid for one year from the date signed and if the entire medical record is to be released or transferred that a separate medical record's release is required.

Please circle all that apply:

TN Cert of Immunization
(Used for schools and daycare)

Other (Please attach form)

Vaccine Administration Record
(This is not for school entrance)

Sports Form

PLEASE COMPLETE THE "PRE PARTICIPATION "FORM AND ATTACH TO YOUR REQUEST. THANK YOU.

(Sports Forms can't be faxed but are available through our Secure Patient Portal on the Website)

Check Your Child's Provider:

___ Brooks ___ Chambers ___ Carr ___ Townsend ___ Couden ___ Hood ___ Peabody ___ Harrison ___ Nicholls

Please Complete the Following:

Child's Name: _____ Date of Birth: _____

Parent or Legal Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Parent's Signature (or Patient's if 18 or older): _____

Date: _____ Telephone Number where you can best be reached: _____

Please Indicate Preference: (Please allow 48 hours for processing your request)

_____ Mail (**Complete self-addressed envelope**)

_____ Fax to: _____ (**Sports Forms Excluded**)

_____ Pick up

Processed & Documented in Chart By: _____ Date: _____