BRENTWOOD PEDIATRICS, PLLC
5111 Maryland Way, Suite 301
Brentwood, TN 37027
Phone 615.661.4256
Fax 615.661.4253

RELEASE OF RECORDS REQUEST

Patient's Name (s) ____
Patient's DOB (s) ____
Relationship to Patient (s) ____

FACILITY TO RELEASE THE RECORDS FROM:

Name: ____
Address: ____
Phone #: ________________________Fax #: _________________________

Please initial below:

__________I authorize the release of my child's medical records in accordance with the specification listed above.

__________I understand this authorization is valid for 1 year unless otherwise stated or cancelled by me with a written notice.

__________I understand that the information above may contain mental health, developmental disabilities, AIDS test results, AIDS related disease diagnosis, drug abuse or other privileged information.

Printed Name of Parent/Guardian: _______________________________________

Signature of Parent/Guardian: ____

Date: _____________________

Please fax or mail records to: Brentwood Pediatrics, PLLC
5111 Maryland Way, Suite 301
Brentwood, TN 37027

Fax: 615.661.4253