RIVERGATE PEDIATRICS

REQUEST FOR RELEASE OF INFORMATION
FOR TREATMENT

Patient name:_____ **DOB:**_____ **SS#**_____

Release information ***TO*:**

_____
_____
_____
_____
_____

Request information ***FROM*:**

Rivergate Pediatrics
807 Meadowlark Lane
Goodlettsville, TN 37072
615-859-6650
Fax 615-851-1983

I am requesting an **electronic copy** of my records **Pt Initials**_____

Description of information to be released: (INITIAL all that apply)

_____**Medical Summary**

_____**All medical records**

_____**Medical Records relating to the following treatment, conditions, or dates of treatment:**_____

_____

_____**Specific records to be released (eg. labs, imaging reports, other):** _____

_____

If you DO NOT WANT certain portions of your medical records released, please initial the information you do not want released.
Reproductive health, STI's/AIDS/HIV_____ **Substance abuse** _____

Psychiatric/Psychological conditions_____ **Other (describe)**_____

I understand that this release will expire on the following date___/___/____(DD/MM/YR) or after records are released or disclosed as per request above.

_____ _____
Signature of patient (if 18 years or older) or patient's representative **Date**
(Pertinent sections of the Form MUST be completed before signing.)

Printed name of patient or patient's representative:_____

Relationship to the patient:_____

If you are transferring records, please tell us why and give us feedback on what we are doing right and/or how we can improve. Use the back if necessary:_____

_____

_____

TO BE FILED IN PATIENTS MEDICAL RECORD