RIVERGATE PEDIATRICS
807 MEADOWLARK LANE
GOODLETTSVILLE, TN 37072
615-859-6650 FAX 615-851-1983

REQUEST FOR RELEASE OF INFORMATION FOR TREATMENT

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

Release information ***TO*:**

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

Request information ***FROM*:**

_____
_____
_____
_____
_____

INITIAL all that apply

1. **I am requesting an electronic copy of my records_____**
2. **Medical Summary and all medical records at this health care provider_____**
3. **Other_____**

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:_____