



865.687.1940 | 865.687.0157 Fax

4741 N Broadway, Ste B | Knoxville, TN 37918

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Patient Authorization for Release of Medical Information

>>> Please **mail** records if over **20 pages!** <<<

Release records to (name, address, phone):

Drs. Black & Benton, PSC
4741 N. Broadway, Suite B
Knoxville, TN 37918
865-687-1940 (o) / 865-687-0157 (f)

Release records from (name, address, phone):

Please release records for the following patient(s):

Patient Name

Date of Birth

Reason for records release (please check and comment as needed):

Moving out of town
 Child too old for pediatrics
 Insurance change
 Scheduling
 Other _____

Not satisfied with physician
 Not satisfied with staff:
 Front Desk Nursing Staff
 Back Desk Billing

Specific records (i.e., labs, progress notes):

Entire medical record
 Health information related to the following treatment or condition _____
 Shot record only

I understand that I may revoke this authorization at any time and that unless an earlier date is specified it will automatically expire 12 months after the date affixed below. Treatment, payment, enrollment or eligibility of benefits are not conditioned on signing the authorization or a description of the consequences to the patient if he or she refuses to sign the authorization. Once the information is used or disclosed, it may no longer be protected. A copy of this authorization may be utilized with the same effectiveness as an original. My signature below indicates that I am authorized to obtain/release records on the patient(s) indicated and there is no court order denying guardianship, parental rights, or authorization to obtain/release these records.

Patient Signature or Authorized Representative

Date Signed

Printed Name

Relationship to Patient