Children's Faith Pediatrics
Phone: 865-690-8778
Fax: 865-694-7507

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT:_____

DATE OF BIRTH:_____

PARENT OR GUARDIAN
(Mother's name at time of child's birth):_____

MOTHER'S SS#:_____

PHYSICIAN WITH RECORDS: TN State Dept. of Health
Laboratory Services
Attn: Mitzi Lamberth,RN

I hereby request that my medical records be released to:

Rick Glover, MD
and /or
L. David Perry, MD
1341 Branton Blvd., Suite 102
Knoxville, TN 37922

SIGNATURE:_____

DATE:_____

Office Use Only:
*FAXED copy requested
Date:_____

*Results not Available
Date:_____

C:\Documents and Settings\usr\My Documents\Request for release.doc