



East Tennessee Pediatric Cardiology, PC

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HIPAA AUTHORIZATION

Our office is permitted by federal privacy laws to make uses and disclosures of your/your child's health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you/your child. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for urgent care or treatment. It also includes billing documents for those services.

A complete copy of the privacy practices is posted in the office lobby for your review.

I acknowledge that I have been informed of the Privacy practices for protected health information.

Patient/Parent/Legal Guardian/Durable medical power of attorney:

Signature: _____ **Date:** _____

RELEASE OF MEDICAL INFORMATION

I give my permission to release medical information regarding my/my child's care to the following persons: (family, and/or friends):

1. _____
2. _____
3. _____
4. _____

This permission will remain in effect until canceled in writing.

Patient/Parent/Legal Guardian/Durable medical power of attorney:

Signature: _____ **Date:** _____

MEDICAL RECORDS RELEASE

I authorize the release of medical information to:

East Tennessee Pediatric Cardiology, PC
2001 Highland Ave, Suite B
Knoxville, TN 37916

Patient name: _____ **Date of birth:** _____

Patient/Parent/Legal Guardian/Durable medical power of attorney:

Signature: _____ **Date:** _____

Date requested: _____ **Fax:** _____ **Mail:** _____