Middleboro
PEDIATRICS

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Authorization to Release Medical Information to or from Middleboro Pediatrics

Patient Information:

Patient Full Name______________________ Date of Birth ______________________

Patient Address______________________ Daytime Phone__________ Evening Phone __________

City______________________ State______________________ Zip______________

Release Information: (circle TO or FROM)
I hereby authorize Middleboro Pediatrics to release medical record information TO/OBTAIN INFORMATION FROM

Name____

Address______________________ Phone__________ Fax______________________

City______________________ State__________ Zip______________________

Purpose of Request: (check one) ___Transfer from Practice ___Referral/Specialty Care/Consultation/Second Opinion
___Legal ___Insurance ___Personal ___Other

If you are transferring from Middleboro Pediatrics please state reason why (age, dissatisfied, insurance, moving, travel distance etc.)______

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Information to be Released:

___Complete Medical Records – excluding protected information.

Authorization to Release Protected Information (required):
I hereby authorize the release of the following protected or privileged information that I have initialed below

__________Mental Health/Psychotherapy Notes/Information__________HIV Tests and Related Information__________Genetic Testing
__________Alcohol/Substance Abuse__________Sexually Transmitted Disease (STD)__________Social Work Counseling/Therapy
__________Rape/Sexual Abuse__________Domestic Violence Victims' Counseling__________Developmental Disability

Authorization/Disclosure:
We will not release information from other facilities or healthcare providers. Please contact them directly for information. I authorize Middleboro Pediatrics to release/obtain copies of the named patient's medical record to the above named person/facility. I release Middleboro Pediatrics and its physicians and staff from all legal liability that may arise from the release of this information. This authorization shall remain in effect for 90 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 years old then the signature of the legal guardian is required.

Signature of patient or legal guardian______________________________ **Date** ______________