Middleboro
PEDIATRICS
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Authorization for MP to RELEASE Medical Information

Patient Information:

Patient Full Name ________________________________ Date of Birth ____

Patient Address __________________________________ Daytime Phone ____________ Evening Phone ______________

City ____ State __________________ Zip Code _______________________

Release Information FROM:

I authorize Middleboro Pediatrics to RELEASE MEDICAL INFORMATION TO:

Name ____ ____

Address ____ Phone ____________________ Fax ________________________

City ____ State ____________________ Zip Code ____________________

Purpose of Request (check one): ____ transfer from practice ____ referral/Specialty Care/Consultation/Second Opinion

____ legal ____ insurance ____ personal ____ other

Information to be released:

____ complete medical records, including protected information **SEE BELOW**

Authorization to Release Protected Information (required):

I DO NOT 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:

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: ___________________