



Middleboro PEDIATRICS

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Authorization for MP to OBTAIN 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 OBTAIN MEDICAL INFORMATION FROM:

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: _____