

PEDIATRIC HEALTH CARE
At Newton-Wellesley, P.C.

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL RECORDS/INFORMATION

Patient Name: _____ D.O.B. _____

Purpose of Disclosure: _____ Changing Physicians _____ School _____ Behavioral Health
_____ Consultation _____ Other

Please check which information you want released:

_____ COMPLETE RECORD (past 3 years) _____ Imaging Results _____ Developmental Notes
_____ Clinical Notes _____ Medication Information _____ Lab Results
_____ STD Results _____ HIV _____ Other: _____

I hereby authorize Pediatric Health Care to (check one)
 RECEIVE **RELEASE** my private health information:

INCOMING to Pediatric Health Care

Please fax or mail records to:

Pediatric Health Care
65 Walnut Street, Suite 310
Wellesley, MA 02481
Ph: 781-772-1527
Fax: 781-772-1497

OUTGOING (circle one) New Provider/Specialist/Patient

Mail Fax Pick-up

Name: _____

Address _____

City _____ STATE: _____ Zip : _____

Phone: _____

Fax: _____

***** OUTGOING RECORDS: Please note there is a \$20 Fee, per patient.**

***** RECORDS WILL BE SENT WITHIN 30 DAYS from the date of request.**

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on this authorization. I must do so in writing and present my written revocation to Pediatric Health Care. I understand that authorizing the disclosure of this information is voluntary. This authorization expires 90 days from the date of the signature listed below. I have carefully read and understand the above and voluntary disclosure of the above information to those persons or agencies listed.

PARENT/Legal Rep Signature (17/younger) _____ Date _____

Patient Signature (18/older) _____ Date _____