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:**

**OUTGOING (circle one) New Provider/Specialist/Patient** □ Mail □ Pick-up

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ Zip :\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Specialists ONLY**

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ INCOMING to Pediatric Health Care**

Please mail records to:

**Pediatric Health Care**

**65 Walnut Street, Suite 310**

**Wellesley, MA 02481**

(we do not accept complete records via fax.)

**For Specialists (clinical note request) ONLY**

Fax: 781-772-1497

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

**\*\*\* RECORDS WILL BE SENT WITHIN 14 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature (18/older) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_