Village Pediatrics
Boston Children's
Primary Care Alliance

AUTHTORIZATION FOR RELEASE OF MEDICAL INFORMATION

Village Pediatrics

Please complete this form completely. Please print.

Your medial record cannot be released until this form is completed and signed by the patient (if 18 years or older) or legal guardian. If the patient or legal guardian requests a personal copy of medical records, a copying charge will be applied. Please consult the medical office sending the records for more information.

Step 1: Information about you

Patient Name: _____ Date of Birth: _____

Current Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Step 2: Records Requested From

I hereby Authorize: Name of Person/Facility _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Step 3: Records to Disclose to

Name of Person/Facility _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Step 4: Information you are Requesting

_____ All Records

_____ Records for dates from _____ to _____ Only

_____ Other Records (please specify) _____

Step 5: Authorization to release any of the following sensitive information or medical records. I authorize the release of the following sensitive information, which may be in my chart:

MUST CHECK YES OR NO FOR EACH

Abortion: ___YES ___NO

AIDS/ARC: ___YES ___NO

HIV testing: ___YES ___NO

Mental Health Visits: ___YES ___NO

Eating Disorders: ___YES ___NO

Alcohol/Drug Abuse: ___YES ___NO

Sexual Assault/Rape: ___YES ___NO

STD's: ___YES ___NO

Step 6: Your Signature and Authorization

This authorization is for the release of medical records as specified in Steps 4 and 5. This request is valid for 90 days and may be revoked at any time by written request.

_____ OR _____ _____

Patient's Signature (18yrs or older) Parent/Guardian Signature Date