Village Pediatrics

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Authorization for the Release of Medical Records

Patient Name _____ **Date of Birth** _____

Patient Address _____

City _____ **State**_____ **Zip** _____

Phone Number _____

Authorization:

I authorize _____ to release my (or the patient's) medical records to the individual or organization listed below. This may include patient histories, office visit notes (excluding behavioral health notes), test results, and radiology studies.

Note: For continuity of care, there is **no charge** for the initial release of records to another doctor or medical facility. A **$25 fee** applies to multiple requests or if records are released to the parent or patient

Important: If your child is **18 years or older**, they **must sign** this form.

Disclose medical records to:

Name:_____

Organization:_____

Address: _____

Phone: _____ **Fax:** _____

Please select one:

- ☐ **Entire medical record (except confidential information defined by Massachusetts law)**
- ☐ **Medical Records for the time from** _____ **to** _____
- ☐ **Only information pertaining to certain illnesses or injuries. Please describe**

_____

Reason for Release (Check one):

- ☐ **Sharing with outside provider for treatment purposes**
- ☐ **Transfer to adult provider**
- ☐ **Moving**
- ☐ **Insurance coverage**
- ☐ **Other; Please describe** _____

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 select Yes or No for each.**

Abortion: Yes__ No___ **AIDS/ARC: Yes__ No__** **HIV testing: Yes__ No__**

Eating Disorder: Yes___ No___ **Alcohol/ Drug Abuse: Yes__ No__** **STD's: Yes__ No __**

Mental Health Visits: Yes__ No__ **Sexual Assault/ Rape: Yes__ No__**

_____ _____

Relationship to Patient **Printed name of parent/ legal guardian**

_____ _____

Signature of parent/guardian/patient if 18 yrs or older **Date**