

**AUTHORIZATION TO RELEASE  
MEDICAL/HEALTH RECORD INFORMATION**

Date of Request: \_\_\_\_\_

Date Request Expires: 90 days from date of request

Patient Names:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I hereby authorize \_\_\_\_\_ to release/disclose medical record information to:

**PEDIATRIC PROFESSIONAL ASSOCIATES, PC**  
**413 BROADWAY**  
**METHEUN, MA 01844**

For the following purpose (please circle):

Medical Care / Insurance / Personal

Other: \_\_\_\_\_

\_\_\_\_\_ Complete Record

\_\_\_\_\_ Records of care from the following dates: \_\_\_\_\_ / \_\_\_\_\_

\_\_\_\_\_ Records concerning the following condition(s): \_\_\_\_\_

\*\* The following items must be initialed to be included in the use and/or disclosure of other health information:

\_\_\_\_\_ \*HIV/AIDS related information and/or records

\_\_\_\_\_ \*Mental health information and/or records

\_\_\_\_\_ \*Genetic testing information and/or records

\_\_\_\_\_ \*Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed) Describe: \_\_\_\_\_

I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it.

I understand that this information will be provided to the intended party within 30 days from receipt of request and that if the intended party is not a medical office/facility that there is a \$15.00 clerical fee and .25 per page for preparing and furnishing this information. The fee must be paid before records are released.

\_\_\_\_\_  
Patient (Parent / Legal Guardian) Signature

\_\_\_\_\_  
Date

**Pediatric Professional Associates, PC**  
**413 Broadway**  
**Methuen, MA 01844**  
**978-683-1974**

**PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.**

**PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION TO NON-HEALTHCARE PROVIDERS**

I, \_\_\_\_\_ (custodial parent name) understand Pediatric Professional Associates, P.C. (PPA) is authorized to use or disclose my child's protected health information for a purpose other than treatment, payment, or healthcare operations, to the non-healthcare providers listed below. I understand that I retain the right to revoke this authorization. Please take a few minutes to consider all possible adults who might accompany or contact our office regarding your child, \_\_\_\_\_, DOB \_\_\_\_\_.

Please write full name of all parties that can be notified regarding your child's health information as deemed necessary for appropriate care. Please specify if entire health history is **NOT** to be disclosed (i.e. labs only, immunizations only).

- \_\_\_\_\_  
Mother
- \_\_\_\_\_  
Father
- \_\_\_\_\_  
Step-parent
- \_\_\_\_\_  
School nurse
- \_\_\_\_\_  
Day Care Provider/ After School Provider
- \_\_\_\_\_  
Grandparents
- \_\_\_\_\_  
Family Friend
- \_\_\_\_\_  
Neighbor
- \_\_\_\_\_  
Other (i.e. Aunt, Uncle, etc...)

My child's parents are divorced. Yes \_\_\_\_\_ No \_\_\_\_\_

This authorization is valid for two years from the date of signature.

All revocations must be sent to PPA to the attention of the Privacy Officer. I fully understand and accept the terms of this authorization.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**For office use only**

Authorization added to patient's medical record on \_\_\_\_\_

Authorization verified by \_\_\_\_\_ on \_\_\_\_\_

Revision: 4/14/03, 6/3/03, 07/17/09, 03/11/10

**PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.**

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

**Patients Name:** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_

**Parents Name:** \_\_\_\_\_

**Record #:** \_\_\_\_\_

**I have been presented with a copy of Pediatric Professional Associates "Notice of Privacy Practices".**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**

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**For office use only:**

**If parent refuses to sign, indicate your attempt to obtain a signature below.**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Time**

**Employee Name:**