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

METHUEN, 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.

____ ______________________________________

Patient (Parent / Legal Guardian) Signature Date

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