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 **PEDIATRIC PROFESSIONAL ASSOCIATES, P.C.** to release/disclose medical record information to:

Name: _____ For the following purpose (please circle):

Address: _____ Age / Insurance / Move / Personal

_____ Other: _____

_____ Complete Record (including original copies of all records forwarded to us by previous doctors, and hard chart if applicable)

_____ 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 PPA will charge me for a digital copy of my medical records and I have been provided a fee schedule.

Please note that information disclosed pursuant to this report is no longer under the control of Pediatric Professional Associates, PC and may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Patient (Parent / Legal Guardian) Signature Date

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

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

You have requested that Pediatric Professional Associates, PC, release your or your childs medical record information to a person or entity outside of Pediatric Professional Associates, PC or that you would like to have a copy of your medical records. In accordance with the law, Pediatric Professional Associates, PC may charge you a fee for this service.

- *For digital copy on USB thumb drive (which is our common practice), there is a flat rate charge of $25.00 and an additional $5.00 for siblings charts on the same USB and due at the time of request. You will have to provide proper ID and sign that you received the electronic records. Once you have signed them out, the USB drive is no longer the responsibility of Pediatric Professional Associates, PC.*
- *For paper copies Pediatric Professional Associates, PC charges $15.00 Clerical Fee and $.25 per page along with any postage and handling*
- *Please note that Pediatric Professional Associates, PC has up to 30 days to process your request for medical records.*

I understand and agree to the fees and policies explained above.

Print Name: _____

Signature: _____

If I am unable to pick up my records I authorize Pediatric Professional Associates to release my medical records to:

Name:_____

Relationship: _____