Authorization for the Release of Health Information

Neponset Valley Pediatrics
Boston Children's
Primary Care Alliance

neponsetvalleypediatrics.com
781-784-0403 | *fax* 781-784-0407

Patient name: _____

Date of birth: _____

Address: _____

Phone: _____

I authorize the records from:

Name/Facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released

I request that the following information be released for the purpose of medical treatment:

❏ Birth records
❏ Medical history and treatment
❏ Immunization records
❏ Lab results or testing for: _____
❏ Radiology results for: _____

This information should include treatment dates from: _____ to: _____

Important: Records for the following will only be sent if checked YES.

HIV testing	❍ Yes	❍ No
Sexually transmitted diseases	❍ Yes	❍ No
AIDS	❍ Yes	❍ No
Psychological/Psychiatric history	❍ Yes	❍ No
Other: _____	❍ Yes	❍ No

Information will be released to:

Neponset Valley Pediatrics
450 N. Main Street
Sharon, MA 02067
781-784-0403
Fax: 781-784-0407

Authorization

I hereby authorize the release of any medical information as requested above. Information will not be released without a valid signature below.

This authorization will expire one year from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Neponset Valley Pediatrics has relied upon it.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition defined by law.

Parent or legal guardian signature is required for patient under 18 without emancipated status, or a special condition defined by law.

Patient/Parent name: _____

Signature: _____

Date: _____

Office: _____ Date: _____