Staff use Payment received: ❍ Yes ❍ No ❑ Credit ❑ Check # _____ ❑ Cash
❑ OK to copy? ❑ OK to send? Deactivate?: ❍ Yes ❍ No

Neponset Valley Pediatrics
Boston Children's
Primary Care Alliance

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

Medical Record Release

Today's date: _____

Last name: _____

First name: _____ Middle initial: _____

Date of birth: _____

Parent/Legal guardian: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____

Work phone: _____

Email: _____

Patient's primary care provider:

_____

Release records for these additional patients:

Patient 2: _____ Date of birth: _____

Patient 3: _____ Date of birth: _____

Patient 4: _____ Date of birth: _____

Records to be released

I, (Name): _____ ,
hereby authorize Neponset Valley Pediatrics to release the following information:

❑ All records
❑ Consultation notes
❑ Discharge summary/Emergency records
❑ Office visits
❑ Pathology lab reports
❑ Radiology reports (ultrasounds, x-rays, MRI, CT scans)

Dates of service for requested release:
❍ All dates ❍ Dates from: _____ to: _____

Information related to AIDS, HIV infection, sexually transmitted diseases, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse is authorized under this release.

❍ Yes ❍ No

Reason for release

❑ Moving out of the area ❑ Legal (not leaving)
❑ Adult MD ❑ Other: _____

Payment

Processing fee is **$15.00 per record** and must be paid prior to release. We also request that all patient accounts be paid prior to releasing records.

Card number: _____

Exp. date: _____ CVV code: _____ Amount: _____

Signature: _____

❑ By checking this box, I authorize the processing of this card as the above named card holder.

If paying by check, is it enclosed? ❍ Yes ❍ No

Check amount: $ _____ Check #: _____

Delivery of records

Records will be provided on CD and sent via U.S. Mail. Please send to:

❍ Myself ❍ Another provider at the address listed below:

Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient/Parent/Legal guardian signature:

_____

Printed name: _____

Relationship to patient: _____ Date: _____

Return this form at check-out, by mail, or fax

Mail: **Neponset Valley Pediatrics**
450 North Main St., Suite 2
Sharon, MA 02067

Fax: **781-784-0407**

Credit card payments may also be made by calling our office at **781-784-0403**.