Medical Record Release

Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance

belmontcambridgehealthcare.com
617-491-5111 | *fax* 617-491-5222

Patient information

Last name: ____

First name: ________________________________ MI: __________

Date of birth: ____

Phone: ___________________________________ ❍ Cell ❍ Other

Address: __________________________________ Apt #: ______

City: ____________________________________State: _________

Zip: ____

Transfer of medical records

Release records ❍ To ❍ From

Name/Facility: ____

Address: ____

City: ____________________________________State: _________

Zip: ____

Specific information to be disclosed and released

❍ Medical record from this date: _____________________________

to this date: ____

❍ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults.

Comments: ____

____

____

Specific information to be withheld

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. I have indicated below that I do or do not permit information of this type, if it exists, to be released. I understand that if I do not indicate a choice, Belmont Cambridge Health Care will release such information about me if it exists.

HIV/AIDS infection .... ❍ Yes ❍ No

Genetic information .... ❍ Yes ❍ No

Mental health .... ❍ Yes ❍ No

Sexually transmitted diseases .... ❍ Yes ❍ No

Treatment for alcohol and/or drug abuse .... ❍ Yes ❍ No

Specific information to understand

- I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
- It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Belmont Cambridge Health Care. I understand that any previously disclosed information would not be subject to my revocation request.
- A $25 fee applies for records mailed to another facility or provider.

Reason for release of medical records

❑ Transfer to an adult provider

❑ Moving away to:

City: _______________________________ State: _____________

❑ Insurance change

❑ Providers not in new network

Network name: ____

❑ Tiering/higher co-pay/higher deductible cost

❑ Long wait times

❑ Management of my child's health care

Please elaborate: ____

❑ Unsatisfactory staff interaction

Please elaborate: ____

❑ Other: ____

Authorization

Signature of parent/guardian (or patient if over 18):

____

Name (print): ____

Relationship to patient: ____________________________________

Date: ____