Boston Children's Hospital

Use Plate, Label, or Print:

Name:

CH MRN#:

DOB: Gender: M F

150592

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION FROM A NON-CHILDREN'S PROVIDER

Demographics

Patient Last Name		First Name		MI	
Home Street Address				Apt#	
City		State		Zip	
Date of Birth		Telephone	( )		

Information Requested

I authorize the release of the following information of the patient named above to Boston Children's Hospital

Please provide COPIES OF MOST RECENT:

☐Cardiology Clinic Notes	☐Echo- CD & Report	☐Genetic Testing
☐EKG & Reports	☐ Holter Monitor Reports	☐OTHER:
☐ Genetics Clinic Notes	☐MRI Scan- CD & Report	

Purpose of Release: Continuing Care/ Consult at BCH

Release Information From

I am requesting the above information from the following healthcare provider(s)

Name/Facility:	
Fax:	**Telephone:**
Name/Facility:	
Fax:	**Telephone:**
Name/Facility:	
Fax:	**Telephone:**
Name/Facility:	
Fax:	**Telephone:**
Name/Facility:	
Fax:	**Telephone:**
Name/Facility:	
Fax:	**Telephone:**

Signature of Patient	Name of Patient (please print):	Date:
Signature of Parent or Guardian (If patient is under the age of 18)	Name of Parent or Guardian (please print):	Date:
Relationship to the patient:		

Information will not be released without a valid signature above. Unless otherwise revoked, this authorization expires 12 months from the signature date or otherwise specified date: ___ ___ _____

Please send the requested information to:

Boston Children's Hospital Attn: CVG Admins	
300 Longwood Ave. Boston, MA 02115	
Fax 617-730-4601	**Telephone 617-355-8794**

Please make a copy of this release for your records.

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