BRAMBLEBUSH PEDIATRICS

Authorization for Release of Information

By signing this form, I authorize you to release a copy of my medical records to the person or entity listed below.

NAME _____ DATE OF BIRTH_____

ADDRESS_____PHONE_____

CITY _____STATE_____ZIP_____

I hereby authorize: **BRAMBLEBUSH PEDIATRICS L.L.P.**

Address: **_15 Bramblebush Park**_____

_Falmouth, MA 02540_____

Phone: **_508 548 6969**_____

To release copies of my medical record to:

Name: _____

Address: _____

_____

For the purpose of: __Personal __Insurance __Legal __Move Other:_____

This authorization shall remain in effect for 90 days unless specifically revoked in writing.

Signature of patient or legal representative: _____Date_____

Relationship to patient:_____

Sensitive Information Authorization: Separate authorization is required to release sensitive information such as abortion, substance abuse, genetic information, mental health notes sexually transmitted diseases, rape or abuse.

Signature of patient or legal representative:_____Date_____

HIV/AIDS Information Authorization: Specific authorization is required for and HIV related information.

Signature of patient or legal representative:_____Date_____

PLEASE BE AWARE OF $20 COPYING FEE FOR RECORDS