Authorization for Release of Medical Records

Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

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978-957-4300 | *fax* 978-957-3891

Patient name: _____

Date of birth: _____

Address: _____

Phone: _____

I authorize the release of medical 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: _____

Range of dates for information to be released

from: _____ to: _____

NOTE 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:

Alena Ashenberg, MD Pediatrics
505 Nashua Road, Suite 5
Dracut, MA 01826
Fax: 978-957-3891

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 Alena Ashenberg MD, Pediatrics has relied upon it.

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

A parent or legal guardian signature is required for patients under 18 years old, without emancipated status, or a special condition defined by law.

Patient name (if 18 or older):

_____

Signature: _____

Parent/Guardian name (if under 18):

_____

Signature: _____

Date: _____