AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Step 1: Information about you:

Patient Name: _____ DOB:_____

Address:_____Phone:_____

Step 2: Reason for requesting your medical records:

Please tell us why you are releasing your medical information**:**_____

Step 3: Where you want the records sent:

I hereby authorize the use and/or disclosure of protected health information about my child/ me as described below.

- ❑ All records
- ❑ Abstract Records (All records pertaining to the last two years of care)
- ❑ Dates of treatment _____ to _____

TO or FROM:	**TO or FROM:**
Neighborhood Pediatrics **881 South Street** **Suite 3** **Fitchburg, MA 01420**	**Name/Facility:**_____ **Address:**_____ _____ **Phone:**_____ **Fax:**_____

Step 4: Your signature:

This authorization may be revoked in writing at any time. Transfer to any other recipient requires a separate authorization. This authorization expires one year from signed date, unless otherwise specified.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

Patient/Parent/Guardian Signature: _____ Date: _____

Step 5: Release of statutorily protected information:

I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatrist, reproductive health care, STD, HIV results, social service, genetic testing, Hepatitis B testing/treatment, and/or sensitive info, I agree to its release.

Patient/Parent/Guardian Signature: _____ Date: _____