AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Step 1: Information about you:

Patient Name:_____ DOB:_____

Parent/Guardian Name:_____

Address:_____

Phone: _____

Step 2: Reason for requesting medical records:

- ☐ Coordination of Medical Care
- ☐ Transfer of Medical Care

Reason:_____

_____

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 (Paper and electronic health records)
- ☐ Abstract Records (All records pertaining to last two years of care)
- ☐ Dates of Treatment _____ to_____

Circle one: **TO** or **FROM**:

Neighborhood Pediatrics
881 South Street
Suite 3
Fitchburg, MA 01420
P- 978-342-4437
F- 978-343-6572

TO or **FROM**:

_____
_____
_____
_____
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 the signed date**,** unless otherwise specified. I understand that the information used or disclosed may be subject to re-disclosure by the privacy regulations. I understand that I have a right to refuse to sign this for, and that I am under no obligation to sign this for and the person(s) and/or organization listed above who I am authorizing to authorization.

Patient/Parent/Guardian Name:_____ Date:_____

Signature: _____

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, social service, genetic testing, Hepatitis B testing/treatment, and/or sensitive information, I agree to its release.

Signature: _____