TRI-COUNTY PEDIATRIC ASSOCIATES, P.C.

907 Sumner Street, Suite M-102, Stoughton, MA 02072
Ph: 781-344-3791 Fax: 781-341-3614

Authorization for the Release of Medical Information

PATIENT INFORMATION:
Patient Name:_____ Date of Birth:_____
Address:_____
Day time phone # :_____ Evening phone # :_____

____ RELEASE MEDICAL RECORD TO ____ OBTAIN MEDICAL RECORD FROM

Name:_____
Address:_____
Phone #:_____

PURPOSE OF REQUEST:

___ Transferring all care to new physician
___ Specialty Care – remaining at Tri-County Pediatrics
___ Consult / second opinion
___ Personal Use
___ Other (please specify)_____

REASON:

Are you leaving because of an insurance change? __yes __no If yes, new insurance_____
Are you transferring your care to an adult doctor? ___ yes ___no
Are you transferring your care because you are dissatisfied? ___yes ___no
Do you have any appointments you would like us to cancel? ___ yes ___ no Dates _____

INFORMATION TO BE RELEASED (please specify dates):

___ Immunizations and last physical ___ X-rays/ Scan reports – specify dates_____
___ most recent 5 year history ___ Laboratory reports – specify dates _____
___ other (please specify)_____

DATE NEEDED:

____ Normal processing time 2-3 weeks Future appointment date_____
___ Other (please specify) _____

AUTHORIZATION/ REDISCLOSURE:

We will not release information from other facilities or health care providers. Please contact them directly for information. I authorize Tri-County Pediatric Associates, P.C. to release copies of the above named patient's medical record to the above named person/facility. I release Tri-County Pediatric Associates and its physicians from all legal liability that may arise from the release of this information. This authorization shall remain in effect for 90 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 years and then the signature of the legal parent or guardian is required.

Date **Signature of patient or legal guardian** **Relationship to patient**

SENSITIVE INFORMATION RELEASE:
I understand that if the above named patient's medical record contains information pertaining to venereal/sexually transmitted disease, treatment for alcoholism, drug rehabilitation, treatment for substance abuse, confidential information acquired by social workers, confidential communications with mental health counselors or confidential communications with domestic violence victim's counselors that I specifically authorize its release.

_____

Date Signature of patient or legal guardian Relationship to patient

HIV and AIDS INFORMATION:
I understand that if the above named patient's medical record contains HIV and /or AIDS information that I specifically authorize its release. This authorization is valid for this release only.

_____

Date Signature of patient or legal guardian Relationship to patient