West Cambridge Pediatric & Adolescent Medicine

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Authorization To Release Information

I,_____, authorize West Cambridge Pediatric & Adolescent Medicine to release medical information and /or copies of medical record of:

Patient's name: _____Patient's D.O.B._____

Parent/Guardian:_____ or to:

Name of Physician/Practice/Hospital:_____

Address:_____

City, State, Zip code_____

This medical information includes the following types we have in our possession. We will release records created at the practice.

As per Massachusetts and/or Federal Law, certain types of medical information is protected by law from release without specific consent, and will not be released as a result of this authorization. If you **DO NOT** want these records released, please check the appropriate line(s) below:

___AIDS/HIV testing and results
___Mental Health records and references
___Substance abuse (alcohol, narcotics, prescription drugs)
___Communication with psychologist.
___Sexually transmitted diseases
___Termination of pregnancy
___Adoption

PLEASE TURN OVER TO COMPLETE SIDE 2

Please check one of the lines below:

___Transfer patient out of West Cambridge Pediatric and Adolescent Medicine
___Please forward copies of visits pertinent to my specialty care visit

Your reason for transferring from West Cambridge Pediatrics and Adolescent Medicine:

_____.

Signature_____ Date _____
Parent or Guardian of Children Under 18 Years of Age

Signature_____ Date_____
Patient 18 Years of Age or Older

Please allow 5 full business days for the release of information.

There is a $15 charge for all record transfers.

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