Authorization for Release of Medical Information

Framingham Pediatrics
Boston Children's
Primary Care Alliance

framinghampediatrics.com
508-879-5764

I hereby authorize you to release the records of:

Patient name: ____

Date of birth: ____

Address: ____

City: ______________________________________ State:_________

Zip:___________________________________

Home phone:____

Cell phone: ____

Reason for request

❍ Specialist consultation, still a patient of Framingham Pediatrics.

Date of appointment: _______________________________________

Specialty: ____

❍ I will no longer be a patient of Framingham Pediatrics.

Reason: ❑ Age ❑ New insurance ❑ Moving out of area

❑ Other, please explain: _____________________________________

Please release the following information:

❍ **Electronic Medical Record (EMR) only**
Contains all electronic medical records since July 2005, dates of all vaccines given since birth, a medical summary and growth curves. Available within 2–4 weeks. No fee.

❍ **Entire medical record**
Includes documents that may be in storage. $25.00 fee.
Please note it may take up to 60 days to obtain this information as paper charts are stored offsite.

Release of sensitive information

If the medical records referred to above contain information in reference to drug and/or alcohol abuse, psychiatric illness, venereal disease, social services, hepatitis B testing/treatment, and/or sensitive information, I agree to its release.

❍ Yes ❍ No

Release records to:

Doctor/Facility name: _______________________________________

____

Phone: ____

Fax : ____

Address: ____

City: ______________________________________ State:_________

Zip:_____________________

Signature

Signature of parent/guardian, or patient if over 18:

____

Date: ____