Authorization to Release Medical Records

Today's date: _____

Patient(s) Name(s): _____

DOB: _____

I, _____, authorize Marblehead Pediatrics to release all records, including, but not limited to treatments, test results, reports, and to also include medical records which may contain information concerning treatment of any physical or mental conditions. Further, any test results or reports from specialists which may be in the medical record may also be released. In addition, I also authorize the release of psychiatric/psychotherapy, mental health, drug and alcohol treatment information. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, **AT YOUR REQUEST,** to the here below named person or facility.

Please indicate very specifically by circling above any information you wish to exclude from this release.

Patient/parent/legal guardian:_____

In addition to the above, if you want your HIV (AIDS) testing/treatment records released you must sign and date on the line below.

I agree to the release of this information.

Person requesting medical records_____DATE_____
Relationship to Patient:_____
Witness:_____

Transferring to: _____
Address: _____
_____

Reason for Transfer or Request of copies of medical records:

1. Age transfer
2. Moving
3. Other, please explain:
   _____
   _____
   _____

Please Note:

1. There may be a $20.00 charge per child to cover our administrative costs of processing this request.
2. Medical Records cannot be released on demand. Every effort will be made to send records within ten (10) business days after the signed release has been received and fee has been paid.