HARDING PEDIATRICS
45 OAK AVE,
WORCESTER MA 01605
Ph: 508-756-2020 Fax: 508-756-0705

Authorization to Disclose Medical Record Information

Completed by (For office use only) :

Initials:____________ Date:__________

PATIENT INFORMATION

Patient's Name: D.O.B
Address:

Phone Number:

RELEASE INFORMATION

I hereby authorize Harding Pediatrics to: ☐ **Mail my medical records to: ($20.00 fee)** ☐ **Obtain my medical records from:**

Name/ Facility:______________________ Phone:______________________________

Address:____________________________ Fax:________________________________

City:_______________________________ State:_____ Zip:______

Purpose of Request: ☐ Transfer of Care (New Physician) ☐ Personal ☐ Continuing Care (Referral /2d opinion

Reason for Transfer ☐ Moving ☐ Dissatisfied ☐ Other_________________________

Harding Pediatrics charges a $15 fee to pick up records and $20 to mail.
In accordance with Massachusetts law (MGL chapter 111;section 70)

INFORMATION TO BE RELEASED

☐ Entire Medical Record

☐ Office Visits: From_______to_________* ☐ Bills: From _________ to _________*

☐ Lab Results : From _________ to _______* ☐ Radiology Reports: From ________to________*

**** Please specify date range***

STATUTORILY PROTECTED INFORMATION

The following items WILL NOT be included unless specifically authorized

☐ Psychiatric Health - including Behavioral Medicine Notes Intital:_______ ☐ Abortion Intital:______

☐ Sexually Transmitted Diseases Intital:_______ ☐ Alcohol/Drug Abuse Treatment Intital:_______

☐ HIV/AIDS Results Intital:_______ ☐ Genetic Testing Intital:_______

** I understand that I have a right to revoke this authorization at any time by providing a written statement to Harding Pediatrics.*
I understand this authorization is valid for 90 days unless otherwise specified or revoked. Please specify expiration date if less than 90 days: ____/______/______.
** I understand that authorizing the disclosure of this health information is voluntart. I need not sign this form in order to assure treatment.*

** I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and may not be protected by federal confidentiality rules.*

SIGNATURES

Patient/Legal Representative Signature:_______________________Date:______________________

Print Name of Legal Representitive:____________________________Relationship to Patient:___________________

This authorization must be completed in its entirety or it will not be processed