

Framingham Pediatrics, P.C.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize you to release the records of:

NAME: _____ DATE OF BIRTH: _____

CURRENT ADDRESS: _____ FORMER / FUTURE ADDRESS: _____

PHONE NUMBER: HOME: _____ CELL: _____

REASON FOR REQUEST:

_____ Specialist Consultation but will remain 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:

_____ **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** (Including 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 off-site)

RELEASE RECORDS TO: _____

AUTHORIZED SIGNATURE

*****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 service, Hepatitis B testing/treatment, and/or sensitive information, I agree to its release.

Signature of Patient (over 18) or Legal Guardian

Date