Alena Ashenberg M.D. Pediatrics, LLC
505 Nashua Road Suite 5
Dracut, MA 01826
Fax 978-957-3891
Ph. 978-957-4300

We are required by law to obtain your written permission to release your medical record:

Patient Name:_____ Date of Birth:_____

Address:_____ Telephone:_____

City, State, Zip:_____

I hereby authorize the release of the medical records obtained in the course of my/my child's treatment for the purpose of transferring out of this office.

From: Alena Ashenberg M.D. Pediatrics, LLC **To**:_____
505 Nashua Road Suite 5 Address:_____
Dracut, MA 01826 City,State,Zip:_____
978-957-4300 Telephone:_____

The specific information to be released is: **Circle:** Entire Record Summary

If my initials appear here_____, I specifically authorize release of **drug, alcohol abuse, sexually transmitted disease and/or counseling/psychiatric records.** I understand that my **drug treatment** records are protected under federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

If my initials appear here_____, I specifically authorize release of my records that contain information about my **HIV** diagnosis, tests or treatment of **HIV** and **AIDS**.

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclose of the above information, or medical records to those person or agencies named above.

I understand this authorization is subject to revocation at any time, except to the extent that disclosure made in good faith has already occurred. Revocation must be in writing. This authorization will expire 1 year from the date signed. Information released may be subject to redisclosure by recipient.

_____

Date Signature of Patient/Representative Relationship of Representative

Picked up at office by:_____Date_____

Mailed to:_____

Date:_____