Westwood-Mansfield Pediatric Associates

Westwood Office
541 High Street
Westwood, MA 02090
(781) 326-7700
Fax (781) 251-0910

Mansfield Office
454 Chauncy Street
Mansfield, MA 02048
(508) 339-9944
Fax (508) 452-3898

Easton Office
115 Main Street
Easton, MA 02356
(508) 535-5535
Fax (508) 238-1315

www.wmpeds.com

MEDICAL RECORD RELEASE

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Address: _____

RELEASE INFORMATION TO

Name/Facility: _____

Address: _____

_____

SPECIFIC INFORMATION TO BE RELEASED:

- Information to be disclosed:
  - ☐ Medical record from this date _____ to this date _____.
  - ☐ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults.
    Comments: _____

SPECIFIC INFORMATION TO BE WITHHELD:

- To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check marks(s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, Westwood-Mansfield Pediatric Associates will release such information about me if it exists.
  - ☐ HIV/AIDS infection
  - ☐ Genetic information
  - ☐ Mental Health
  - ☐ Sexually transmitted diseases
  - ☐ Treatment for alcohol and/or drug abuse

SPECIFIC INFORMATION TO UNDERSTAND:

- I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
- It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Westwood-Mansfield Pediatric Associates. I understand that any previously disclosed information would not be subject to my revocation request.

Please complete this form on the following page…

Boston Children's Hospital
Community of Care
Preferred Pediatric Practice

Westwood-Mansfield Pediatric Associates

Westwood Office
541 High Street
Westwood, MA 02090
(781) 326-7700
Fax (781) 251-0910

Mansfield Office
454 Chauncy Street
Mansfield, MA 02048
(508) 339-9944
Fax (508) 452-3898

Easton Office
115 Main Street
Easton, MA 02356
(508) 535-5535
Fax (508) 238-1315

www.wmpeds.com

REASON FOR RELEASE:

In an effort to better serve our patients, it is important for us to understand the reason that your child/young adult is leaving our practice. Please select the reason below and provide a description as well. You may utilize the back of this form if more space is needed.

- ☐ Transfer to an adult provider
- ☐ Moving away to: (city) _____ (state) _____
- ☐ Insurance change
  - Providers not in new network (network name) _____
  - Tiering/higher co-pay/higher deductible cost
- ☐ Long wait times
- ☐ Management of my child's healthcare
  - Please elaborate: _____
- ☐ Unsatisfactory staff interaction
  - Please elaborate: _____
- ☐ Other: _____

THIS FORM MUST BE FULLY COMPLETE BEFORE SIGNING:

_____
Signature of Patient or Patients Legal Representative

_____
Print Patients Name

_____
Print Name of Legal Representative (If applicable)

_____
Relationship to Patient

_____
Date