Authorization for Release of Medical Information

Framingham Pediatrics
Boston Children's
Primary Care Alliance
framinghampediatrics.com
508-879-5764

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