Records Release Authorization

Walden Pond Pediatrics
Boston Children's
Primary Care Alliance

waldenpondpediatrics.com
978-369-9401 | *fax* 978-371-8810

Patient name: ____

Date of birth: ____

Reason for disclosure

❍ Transferring care to another provider
Effective date of transfer: _________________________________

❍ Other
Please specify reason: ___________________________________

Information to be disclosed

❍ Entire medical record

❍ Record covering the following dates only
From: ____
To: ____

❍ Other
Please specify details: ____________________________________

Information to be disclosed to

Name: ____

Address: ____

City: __________________________ State: _____ Zip: _________

Fax: ___________________________

Disclosure of sensitive information

Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release.

A check indicates that you **do want** to include the information.

Not checking the statement indicates you **do not want** to include the information.

❏ HIV/AIDS testing or treatment

❏ Pregnancy/Sexual health

❏ Substance use/Abuse

❏ Social work notes

❏ Mental/Behavioral health information

Re-release of information

❏ I authorize Walden Pond Pediatrics, PC to re-release records from other physicians or facilities that may be included in the medical record (i.e.: letters from consultants).

Authorization

Parent/Guardian name: ______________________________________

Relationship to patient: ______________________________________

Signature of parent/guardian (or patient if over 18):

____

Date: ____