

132 Central Street, Suite 116
Foxborough, MA 02035
508-543-6306
FAX 508-543-2976



155 South Street
Wrentham, MA 02093
508-384-7867
FAX 508-384-8119

Authorization for Release of Medical Records and Information

Please allow up to fifteen (15) business days for completion.

\$30.00 Payment is due at time of request.

Cash Check # _____ Credit Card

Medical records will be sent USPS Certified Mail (signature required) to:

Name: _____

Address: _____ City: _____ State: _____ Zip+4: _____

Patient Name and DOB: _____ Age: _____

Best Contact Number: () _____ - _____

I, _____, authorize Pediatric Specialists of Foxboro and Wrentham to release my (my child's) **entire** medical record.

For the following purpose(s):

- | | |
|---|--|
| <input type="checkbox"/> Leaving Practice | <input type="checkbox"/> Insurance Reasons |
| <input type="checkbox"/> Legal Matter | <input type="checkbox"/> Personal Reasons |
| <input type="checkbox"/> Medical Care | <input type="checkbox"/> Specialist(s) |
| <input type="checkbox"/> Other: _____ | |

Information to be released (please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Entire Medical Record | <input type="checkbox"/> Lab & X-Ray report(s) only |
| <input type="checkbox"/> Specialist(s) Notes (include specialists' name) _____ | |
| <input type="checkbox"/> Other: _____ | |

I request the release of the following protected information and confidential details of (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Alcohol and Drug abuse records protected by the Federal Confidentiality Rules [42 CFR Part II] | |
| <input type="checkbox"/> Professional Service(s) of a license Psychologist | |
| <input type="checkbox"/> Social work counseling/therapy | |
| <input type="checkbox"/> HIV Test Results | <input type="checkbox"/> Psychotherapy notes |
| <input type="checkbox"/> Domestic violence counseling | <input type="checkbox"/> Sexual Assault Counseling |

***Release of Protected Health Information from outside of Pediatric Specialists:** Request of records means records created from a period of time while the person(s) listed above have been patients at Pediatric Specialists of Foxboro and Wrentham. If records from an outside agency (laboratory, specialists, etc.) are included, Pediatric Specialists cannot attest to the completeness or accuracy of those records.

Signature of Parent (if under 18) or Patient (if 18 or above)

Relationship to patient: _____ Today's Date: _____

(Request only valid for 6 months from today)