Authorization for Release of Medical Information from Holliston Pediatric Group

Release Information from:
Holliston Pediatric Group

Holliston Office: p. 508.429.2800; f. 508.429.7913
100 Jeffrey Avenue, Holliston, MA 01746

Milford Office: p. 508.478.5996; f. 508.482.9147
321 Fortune Blvd., Milford, MA 01757

Today's Date: _____

Patient Identification:

_____ / / _____

Patient Name *Patient DOB*

_____

Address

_____

Daytime phone number *Evening phone number*

Release Information to:

_____

Name *Phone Number*

_____

Address

Parents will be called when records are ready. (A picture ID is required when picking up records)

Purpose of Request

◯ Transferring all care to a new physician ◯ Consult/second opinion or referral

◯ Personal use ◯ Moving (Date of Move)_____

Are you transferring because you are dissatisfied? ◯ Yes ◯ No If Yes, Please explain on a separate sheet

Are you leaving because of an insurance change? ◯ Yes ◯ No If Yes, name of new insurance_____

Do you have any scheduled appointments you would like us to cancel? ◯ Yes ◯ No

If Yes, list date(s)_____

Information to be Released

◯ Holliston Pediatric chart notes ◯ Laboratory reports ordered by HPG

◯ Specialist notes – when care has been initiated by a HPG provider

◯ Other Records (specify)_____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA

AUTHORIZATION:

I authorize Holliston Pediatric Group to release copies of the above named patient's medical record to the above named person/facility. This authorization shall remain in effect for 30 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 and /or the legal representative presents legal proof of representation.

Date	Signature of patient or legal representative	Legal representative relation to patient
_____	_____	_____

SENSITIVE INFORMATION AUTHORIZATION:

I understand that if the above named patient's medical record contains information pertaining to venereal/sexually transmitted disease, abortion treatment for alcoholism, drug rehabilitation, treatment for substance abuse, confidential information acquired by social workers, confidential communications with mental health counselors or confidential communications with domestic violence victim's counselors that I specifically authorize release. This authorization is valid for this release only.

Date	Signature of patient or legal representative	Legal representative relation to patient
_____	_____	_____

HIV AND AIDS INFORMATION AUTHORIZATION:

I understand that if the above named patient's medical record contains HIV and/or AIDS information that I specifically authorize its release. This authorization is valid for this release only.

Date	Signature of patient or legal representative	Legal representative relation to patient
_____	_____	_____

Please fill-out and sign and return both pages of this Authorization for the Release of Medical Information.
25¢ per page plus handling and postage
Thank you.