Neponset Valley Pediatrics

Authorization for the Release of Health Information

Patient's Name_____ Date of Birth_____

Address_____ Phone _____

_____

I authorize the records from:

Name / Facility: _____

Address: _____

_____

Phone / Fax _____

I request that the following information be release for the purpose of medical treatment:

___Birth Records ___ Medical History & Treatment ___ Immunization Records

___ Lab Results/ testing for _____ ___ Radiology Results_____

This information should include treatment dates from_____ to_____

Released to:

Neponset Valley Pediatrics Phone: 781.784.0403

450 NO. Main Street

Sharon, MA 02067 Fax: 781.784. 0407

Important: If your records contain any of the following area and you want copies sent, please check the YES line. Otherwise they will not be sent.

	Yes	No		Yes	No
HIV testing	___	___	Sexually Transmitted Diseases	___	___
AIDS	___	___	Psychological/Psychiatric history	___	___
Other_____				___	___

I hereby authorize the release of any medical information as requested above. Information will not be released without a valid signature below. This authorization will expire 1 year from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Neponset Valley Pediatrics has relied upon it.

*Patient signature is required for patient who are 18 years or older, or who have emancipated minor status, or a special condition defined by law. Parent or legal guardian signature is required for patient under 18 without emancipated status, or a special condition defined by law.

Patient / Parent Signature_____ Date_____

Office _____ Date _____