



Pediatric
Health Care Associates P.C.
From Birth To Twenty-One

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

Home Office: (check one) Peabody Salem Lynn Melrose Reading

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Person completing form: _____ Relationship to Patient: _____

I hereby authorize Pediatric Health Care Associates to OBTAIN the following health information:

- Complete Medical Record
- Sick Visits
- Physicals
- Immunizations / Vaccines
- Lab / X-Ray Reports
- Other (Please Specify): _____

Please obtain the above information FROM:

Please send the above information TO:

Pediatric Health Care Associates
10 Centennial Drive
Peabody, MA 01960
Attention: Records

Reason for request (please check one):

- Ongoing medical care
- Personal use
- Legal matter
- Other (please specify below)

Comments:

RELEASE FORMS MUST BE SIGNED OR THEY CANNOT BE PROCESSED

SIGNATURE: _____ DATE: _____

A parent or guardian MAY NOT sign if the patient is over 18 years of age..

RELEASE FORMS MAY BE MAILED, FAXED OR RETURNED IN PERSON TO ANY OF OUR LOCATIONS