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 RELEASE the following health information:

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

Please release the above information TO:

____

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Reason for request (please check one):

[ ] Ongoing medical care
[ ] Legal matter
[ ] Personal use
[ ] Other (please comment below)

Patient transfer:

[ ] Moving
[ ] Patient is seeking adult care
[ ] Change of insurance
[ ] Dissatisfied with service (please comment below)
[ ] Other (please comment below)

Comments: ____

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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