

NORTH READING PEDIATRICS

Tel. 978.664.4698 Fax 978.664.1485

Authorization For Release of Medical Record Information

Please complete this form

\$35.00 Fee per Child ("Reasonable Fee" governed by Privacy Rule & State Law) fee may differ due to the amount of medical records to be copied.

Please allow up to 30 Business Days for copying records

Authorization of Disclosure of Protected Health Information

Patient Information: (Please Print Clearly)

Name: _____ Date of Birth: _____

Address: _____

Home Tel. # : _____ Work/Cell#: _____

I hereby authorize North Reading Pediatrics to **release /obtain** the following information regarding my medical treatment:

Information to be Released:

Complete Medical Records, without Sensitive Information (ex. Mental Health, STD)

Complete Medical Records, *WITH* Sensitive Information (ex. Mental Health, STD)

Immunization Records Only (**No Fee Charged**)

Receiving Provider and Purpose of Disclosure:

To: _____

Address: _____

Tel.#: _____

Reason for Transfer: _____

***Record to be: _____ Picked up _____ Mailed ***
(please check one)

Statement of Understanding and Signature:

Your signature on this page indicates that you agree to the disclosure or release of medical information described above and that you understand the following:

- This authorization is valid for 90 days from the date of signature.
- You may revoke this authorization at any time by sending a written request for revocation to the provider (Dr. Vladimir Gleyzer). This revocation, however, will not affect any actions taken by the releasing provider before he/she received my written revocation.
- Your medical treatment cannot and will not be dependent upon your signing this authorization.
- The medical information that is the subject of this form *may not be protected by the federal privacy regulations* if or when it is redisclosed by the person, group, or institution you are authorizing to receive it.
- You have the right to receive a copy of this authorization.
- You have the right *not* to sign this authorization.

Signature of Parent/Guardian: _____ Date: _____

Signature if 18yrs or Older: _____ Date: _____

Method of Payment: _____ Date Payment Received: _____