Needham Pediatrics
145 Rosemary Street
Needham, MA 02494

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Please note: Records from the last 10 years will be transferred onto a USB free of charge. We are able to send medical records through a secure email at no charge. Requests for FULL paper copy of medical record (over the last 10 years) will be charged $30. There is a charge for any subsequent copies ($30.00).**

NOTE: Please allow 3-4 weeks for copies of medical records.

Patient Name: _____ DOB: _____

Telephone Number: _____ Email address:_____

Home address:_____

Reason for Disclosure: ( ) transferring care to another provider
( ) other: please specify reason: _____

Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release. A check indicates you DO want to include the information. Not checking the box indicates you DO NOT want to include the information.

Information to be disclosed:
( ) Immunizations and last physical only
( ) Records for the past 10 years and immunizations **OR,**
( ) Full medical record (**do not check both**)

Sensitive Information:
( ) HIV/AIDS testing of treatment
( ) Pregnancy/Sexual health
( ) Mental/Behavioral health information
( ) Social Work notes
( ) Substance use/abuse

Please disclose the information to one of the following:

( ) Patient's new primary care provider
( ) Patient's new primary care provider's email_____

Practice Name: _____

Physician Name: _____

Address: _____

( ) Please forward to my home address listed above.

I authorize Needham Pediatrics, P.C. to release all medical information as requested above. Information will not be released without a valid signature. I understand that I may revoke this authorization by submitting a written notice to Needham Pediatrics, P.C. _____ _____
Signature of patient (if over age 18) Date
Signature of parent/guardian (if under 18)