MEDICAL RECORDS AUTHORIZATION

Authorization for Records From Outside Provider/Entity

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

wmpeds.com
781-326-7700 | *fax* 781-251-0910

Practice requesting records

Please mail or fax requested records here:

Westwood-Mansfield Pediatrics
ATTN: Medical Records
541 High Street
Westwood, MA 02090

Phone: 781-326-7700
Fax: 781-251-0910

* Please note that a patient may designate up to two (2) outside care providers to have permanent authorization to obtain copies of their medical records. This authorization may be revoked at any time upon your request. If you would like the above named care provider to have such access or update existing care providers, please choose one of the following:

❑ Please give the above named care provider authorization to my medical records

❑ Please replace
Existing authorization: _____
with the above named care provider

❑ Please remove the above named care provider's authorization

The purpose or need for disclosure:

_____

Date range of information to be released:

From: _____

To: _____

Please check specific information to be released:

❑ All
❑ Discharge summary
❑ History and physical
❑ Operative reports
❑ Outpatient progress notes
❑ Constitution Reports
❑ Pulmonary function tests
❑ Tissue exam reports
❑ Nuclear medicine reports
❑ Nuclear medicine CD images (bone scan, etc.)
❑ Heart diagnostics
❑ Radiology reports
❑ Radiology CD images (CT/x- ray, etc.)
❑ Lab results
❑ Other (please specify): _____

Practice releasing medical information

Practice information

Practice name: _____

Address: _____

Phone number: _____

Fax (required): _____

Patient information

Patient name: _____

Date of birth: _____

Address: _____

City: _____State: _____

Zip: _____

Daytime phone: _____

Sensitive Information Disclosure:

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. I have indicated below whether I permit information of this type, if it exists, to be released. If no choice is indicated, the information will be released.

HIV/AIDS infection _____ ❍ Yes ❍ No

Genetic Information _____ ❍ Yes ❍ No

Mental Health _____ ❍ Yes ❍ No

Sexually Transmitted Diseases _____ ❍ Yes ❍ No

Treatment for Alcohol and/or Drug Abuse _____ ❍ Yes ❍ No

Disclaimer:

I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

Signature of Patient or Patient's Legal Representative:

_____

Print Patient's Name: _____

Print Legal Representative's Name (if applicable): _____

_____

Relationship to Patient: _____

Date: _____