Fairview Pediatrics
1176 Memorial Drive
Chicopee, MA 01020
(413) 593-1333

AUTHORIZATION TO REQUEST / RELEASE MEDICAL RECORDS

Patient Name: ______________________________ Date of Birth: ______________

Address: ____

Home Phone: ________________________ Cell Phone: ______________________

[ ] **Request For Information FROM ANOTHER AGENCY:**
I give consent to release information **to Fairview Pediatrics** from the medical / treatment record (including psychiatric and/or substance abuse information if applicable), maintained while I was a patient at / treated by: ____.
(Hospital, clinic, physician name and address)

[ ] **Release of Information FROM FAIRVIEW PEDIATRICS:**
I give consent to Fairview Pediatrics to release information form the medical record maintained while I was a patient at Fairview Pediatrics during the period of: ______________________ to:
(Dates of Treatment)
____.
(Name and address of agency to which records are being released)

[ ] **Release for Sensitive Information**
I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric care, venereal disease, social service, Hepatitis B testing, and/or sensitive information, I agree to its release.

____ ____________
Signature of Patient or Parent / Legal Guardian Date

[ ] **Release of HIV Information**
I understand that if my medical record contains information in reference to HIV (AIDS) testing and/or treatment I agree to its release.

____ ____________
Signature of Patient or Parent / Legal Guardian Date

The Specific Information to be Disclosed Is:

[ ] **Office Notes**	[ ] **Laboratory Reports**	[ ] **Physical Exams**
[ ] **Immunization Records**	[ ] **Nutrition Summaries**	[ ] **Legal Reports**
[ ] **School Information**	[ ] **Camp Information**	[ ] **Attorney Reports**

[ ] **Other (Specify):** ____

[ ] **Consent to Disclose Protected Health Information to Parent / Guardian / Representative**
I, __________________________ give Fairview Pediatrics permission to speak with and/or release information to ____.

Information [ ] May [ ] May Not be released via telephone.

Patient Signature: ______________________________ Date: ______________

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by Federal Regulations.

UNLESS OTHERWISE INDICATED THIS CONSENT WILL EXPIRE IN SIX (6) MONTHS

____ ________________
Signature of Patient Date Signed

____ ________________
Signature of Parent / Guardian / Legal Representative Date Signed

______________________ ___________________ ________________
Signature of Witness Relationship Date Signed

For Fairview Pediatrics Use Only:

Form of ID : _________________________ Verified By: ____________________

Copy Fee Collected: [ ] $20.00 for Medical Record Pick up in office by Patient / Parent.

[ ] $25.00 for Medical Records mail transfer to another agency.