Authorization for Release of Medical Information

Wakefield Pediatrics
Boston Children's
Primary Care Alliance

wakefieldpedi.com
781-245-2203 | *fax* 781-245-7303

Patient name: _____

Date of birth: _____

Information requested from:

Elena Gorlovsky, MD and Enmei Wang, MD
Wakefield Pediatrics
15 Richardson Avenue, Wakefield, MA 01880
781-245-2203

Records to be sent to:

❍ Myself ❍ Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Information to be disclosed

NOTE: A $15 medical record transfer fee applies.

❑ Complete medical record
❑ EKG reports
❑ Physical therapy
❑ Discharge summary
❑ X-ray reports
❑ Emergency reports
❑ Consults
❑ Laboratory
❑ Immunizations
❑ Outpatient reports
❑ Pathology
❑ Other: _____

Protected Health Information (PHI)

I understand that my specific consent is necessary to disclose information pertaining to treatment and/or diagnosis of mental health conditions, substance abuse and/or HIV status.

I understand that authorizing the release of such information does not confirm the existence of such history or treatment.

Drug Abuse/Alcohol	❍ I authorize	❍ I **do not** authorize
HIV/AIDS documentation	❍ I authorize	❍ I **do not** authorize
Psychiatric documentation	❍ I authorize	❍ I **do not** authorize

Purpose of disclosure

❑ Age ❑ Moving/Moved ❑ Insurance

❑ Other: _____

Authorization

I understand that:

- This authorization is valid for 90 days from date of signature.
- I may revoke this authorization at any time in writing, but if I do, it will not affect any actions taken prior to receiving the revocation.
- My medical treatment cannot and will not be dependent upon me 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 I am authorizing to receive it.
- I have the right to receive a copy of this authorization.
- I have the right not to sign this authorization.

Signature of patient/guardian/representative, or patient if over 18:

_____

Date: _____