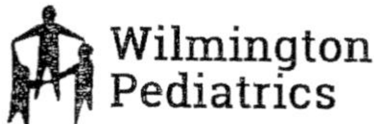

Wilmington Pediatrics Authorization for Disclosure of Medical Record Information

500 Salem Street
Wilmington, MA
Phone: 978-988-6200
Fax: 978-988-6139

Patient Information:

Please Print

Patient Full Name: ______________________ Date of Birth: ______________
Email: ______________________
Patient Address: ______________________ Home Phone: ______________
City: __________ State: ______ Zip: ______ Cell Phone: ______________

Release of Information to:

I authorize Wilmington Pediatrics to release my medical information to:

☐ Mail Copies to: ☐ Discuss medical information with: ☐ Hold for pick up:

Name / Facility: ______________________ Attention to: ______________________
Address: ______________________ Phone: ______________________
City: ______________ State: ______. Zip: ______ Fax: ______________
Purpose of request: ☐ Personal. ☐ Continuity of Care. ☐ Insurance. ☐ Legal. ☐ Transfer of Care

Authorization to release protected Information

*Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not apply to the patient's medical records.

Initial each line below to confirm your choices

☐ I DO. ☐ DO NOT. Want *Psychiatric Treatment Notes released ______
☐ I DO. ☐ DO NOT. Want information about *Sexually Transmitted Diseases released. ______
☐ I DO. ☐ DO NOT. Want information about *HIV Tests & Related Information released. ______
☐ I DO. ☐ DO NOT. Want information about *Alcohol and/or Substance Abuse released. ______
☐ I DO. ☐ DO NOT. Want information about *Genetic Testing released ______
☐ I DO. ☐ DO NOT. Want information about ______________ released ______
Other sensitive information?

Please confirm that you have put a checkmark and initialed ALL the protected information categories above regardless if they are applicable or not. If form is incomplete, or if protected information is not released, Wilmington Pediatric may be unable to fulfill this request.

____
Patient's Signature Date*

____
Parent/Legally Recognized Representative Signature** Date*

____
Witness Date*

*This Authorization is valid for 90 days (30 days for alcohol/drug abuse treatment) unless you specify otherwise: ______________. You may revoke this Authorization at any time by providing a written statement to Wilmington Pediatrics, except to the extent that Wilmington Pediatric has already completed action on it. **By my signature, I attest that I am the legally recognized representative of the above mentioned patient in accordance with the following: ________________. The information release pursuant to this Authorization may be redisclosed by the receiving institution or individual to other individuals or organizations that are not subject to privacy protection laws.