Authorization for the Release of Protected Health Information

Patient's Name_____ Date of Birth_____

Address_____ Phone_____

_____

I authorize the records FROM:
Gleason & Greenfield Pediatrics
240 Wareham Road
Marion, MA 02738

Ph: 508-748-1313
Fax: 508-748-2590

I request that the following information be released **for the purpose of medical treatment:**
__ Birth Records __ Medical History & Treatment __ Immunization Records
__ Lab Results/testing for _____ Radiology Results _____

This information should include treatment dates from _____ to _____

To be released TO:

Name (or Facility) _____
Address_____

_____

Phone/Fax _____

Authorization for the Release of Sensitive or Statutorily Protected Information From the Medical Record

Important: Do your records contain information in the following areas? If you want copies of these records to be included, check the YES line, otherwise they will not be sent.

	Yes	No		Yes	No
HIV Testing	__	__	Sexually Transmitted Diseases	__	__
AIDS	__	__	Psychological/Psychiatric History	__	__
Other_____			Yes__		

I understand that this authorization is good for one year from the date of my signature unless I indicate in writing to the medical records department that I no longer want my/my child's information released. I understand that my withdrawal is effective only if action has not already been taken to release the information. I understand that the information being released may be given to someone else. If this happens, the privacy rules no longer apply and Gleason & Greenfield Pediatrics cannot be held responsible. I understand that if I refuse to sign this form, my treatment will not be affected.

Patient/Parent Signature _____ Date_____

Witness Signature_____ Date_____

Gleason & Greenfield Pediatrics does not provide copies of records which were forwarded to this office. These records should be requested from the original source.