Pediatric Associates of Greater Salem
84 Highland Avenue
Salem, MA 01970
Phone: 978-745-3050
Fax: 978-745-7212

I.D. Verification (copy)
Driver's License _____
School I.D. _____
Professional License _____

AUTHORIZATION TO RELEASE and / or RECEIVE HEALTH INFORMATION

PATIENT NAME _____ DOB _____
First Middle Last

ADDRESS _____ APT# ____ CITY _____ STATE ____ ZIP _____

PATIENT'S PHONE # _____

I authorize **Pediatric Associates of Greater Salem** to (please √) [ ] **release information to** and/or [ ] **receive information from**:

NAME OF AGENCY/PERSON/PROVIDER/PRACTICE: _____

ADDRESS _____ APT# ____ CITY _____ STATE ____ ZIP _____

PURPOSE FOR THIS REQUEST: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one)

□ **Copy of the entire medical record as allowed by law**.
□ Immunization history
□ Billing Records
□ All medical records related to a specific illness or injury: _____
□ Treatment summary (includes history/physical, laboratory tests and x-ray reports, operative reports, pathology)
□ Specific information (Select those that are applicable)
□ Procedure report □ History and physical □ Physical therapy □ Laboratory test results
□ X-ray reports □ Other (Please describe) _____

SENSITIVE INFORMATION: Please read carefully. By law if you want us to release any of the following information from your record, you must sign below: Place your initials next to "Yes" or "No"

Drug/Alcohol Information	Yes _____	No _____
Mental Health, Including ADD/ADHD	Yes _____	No _____
AIDS/HIV Testing and Results	Yes _____	No _____
Sexually Transmitted Diseases, Testing and Results	Yes _____	No _____
Communicable Diseases	Yes _____	No _____

And is limited to the time period from _____ to _____

I understand that

- My right to healthcare is not conditioned on this authorization;
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance to my prior authorization;
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed again;
- There may be a charge per child for the requested records, which can be picked up at the office or mailed for an additional fee.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____

RELATIONSHIP TO PATIENT (if requestor is not patient) _____