Chelmsford/Dracut Pediatrics

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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (18+)

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☐ Drug and Alcohol Abuse Treatment Records

☐ Other (please specify): _____

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Authorize **CHELMSFORD PEDIATRICS, LLC** to disclose the following information from my protected health record to the below listed recipient(s):

☐ I authorize the release of my entire health record (excluding ALL sensitive health information)

I authorize the release of the following records (Check all that apply):

☐ Mental Health Records

☐ Drug and Alcohol Abuse Treatment Records

☐ Other (please specify): _____

I authorize **CHELMSFORD PEDIATRICS, LLC** to provide the above information to:

Name of person/facility: _____

Relationship: _____ For the purpose of: _____

This authorization is valid from the date of signature until **EXPIRATION DATE** _____

This authorization to release information will expire two (2) years following the signature date or on the expiration date noted, whichever comes first.

_____ _____
Signature of patient Date

_____ _____
Signature of Personal Representative Date

Patient's Cell Phone Number (18yo+): _____

Chelmsford/Dracut Pediatrics

Sheila Morehouse, M.D. F.A.A.P.
Jaymi Formaggio, M.D. F.A.A.P.
Jacques Sulahian, M.D. F.A.A.P.
Rebecca T. Kulah, FNP-BC
Eric Meikle, M.D. F.A.A.P.
Megan Cardoso, M.D. F.A.A.P.
Rachael Picciolo, CPNP-PC
Lindsey Gallagher, FNP

7 Village Square, Chelmsford, MA 01824
Tel: 978-256-4363
1385 Lakeview Ave, Dracut, MA 01826
Fax: 978-256-1565

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