30 Tozer Road
Beverly, MA
Phone: 978-745-3050
Fax: 978-745-7014

Pediatric Associates

I.D.Verification
Driver's license □
School I.D. □
State I.D. □

AUTHORIZATION TO RELEASE AND RECEIVE OF HEALTH INFORMATION
Please complete the entire form. An incomplete form will delay processing.

PATIENT NAME _____ DOB _____

ADDRESS _____ APT# ____ CITY _____ STATE ____ ZIP _____

PATIENT'S PHONE # _____

DATE OF REQUEST: _____ DATE NEEDED: ASAP

I authorize **Pediatric Associates of Greater Salem to** □ RECEIVE information from:

NAME OF AGENCY/PERSON _____

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 Record
□ 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 health record, you must initial yes below. If you do not want the information released, please initial no.

Information to be disclosed	**YES**	**NO**
Drug/Alcohol Information		
Mental Health, Including ADD/ADHD		
AIDS/HIV Testing and Results		
Sexually Transmitted Diseases, Testing and Results		
Communicable Diseases		

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 by their previous pediatrician. Pediatric Associates of Greater Salem is not responsible for the payment of the records.
- And is limited to the time period from: _____ to _____.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DATE _____
RELATIONSHIP TO PATIENT: □Self □ Parent □Guardian

Updated 09/25/2020