

Authorization for Release of Medical Records



Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

ashenbergpedi.com
978-957-4300 | fax 978-957-3891

Patient name: _____
Date of birth: _____
Address: _____
Phone: _____

I authorize the release of medical records from:

Name/Facility: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Information to be released

I request that the following information be released for the purpose of medical treatment:

- Birth records
- Medical history and treatment
- Immunization records
- Lab results or testing for: _____
- Radiology results for: _____

Range of dates for information to be released
from: _____ to: _____

NOTE Records for the following will only be sent if checked YES.

- | | | |
|-----------------------------------|---------------------------|--------------------------|
| HIV testing | <input type="radio"/> Yes | <input type="radio"/> No |
| Sexually transmitted diseases | <input type="radio"/> Yes | <input type="radio"/> No |
| AIDS | <input type="radio"/> Yes | <input type="radio"/> No |
| Psychological/Psychiatric history | <input type="radio"/> Yes | <input type="radio"/> No |
| Other: _____ | <input type="radio"/> Yes | <input type="radio"/> No |

Information will be released to:

Alena Ashenberg, MD Pediatrics
505 Nashua Road, Suite 5
Dracut, MA 01826
Fax: 978-957-3891

Authorization

I hereby authorize the release of any medical information as requested above. Information will not be released without a valid signature below.

This authorization will expire one year from the signature date. I can however, cancel this authorization in writing at any time, except to the extent that Alena Ashenberg MD, Pediatrics has relied upon it.

A patient signature is required for patients 18 years or older, who have emancipated minor status, or a special condition defined by law.

A parent or legal guardian signature is required for patients under 18 years old, without emancipated status, or a special condition defined by law.

Patient name (if 18 or older):

Signature: _____

Parent/Guardian name (if under 18):

Signature: _____

Date: _____