Lower Falls Pediatrics
Ph 781-772-1527 Fax 781-772-1497

AUTHORIZATION TO RELEASE/RECEIVE MEDICAL RECORDS/INFORMATION

Patient Name: _____ **D.O.B.** _____

Purpose of Disclosure: _____ Changing Physicians _____ School _____ Behavioral Health
_____ Consultation _____ Other

Please check which information you want released:

_____ COMPLETE RECORD (past 3 years) _____ Imaging Results _____ Developmental Notes
_____ Clinical Notes _____ Medication Information _____ Lab Results
_____ STD Results _____ HIV _____ Other: _____

I hereby authorize Lower Falls Pediatrics to (check one) □RECEIVE □RELEASE my private health information:

□ **INCOMING to Lower Falls Pediatrics:**

Please mail records to:

Lower Falls Pediatrics

65 Walnut Street, Suite 310

Wellesley, MA 02481

(we do not accept complete records via fax.)

For Specialists (clinical note request) ONLY

Fax: 781-772-1497

OUTGOING (circle one) New Provider/Specialist/Patient

□ Mail □ Pick-up

Name: _____

Address _____

City_____ STATE: _____ Zip :_____

Phone: _____

For Specialists/MD ONLY

Fax: _____

***** OUTGOING RECORDS: Please note there is a $20 Fee, per patient.**

***** RECORDS WILL BE SENT WITHIN 14 DAYS from the date of request.**

I understand that I have the right to withdraw my authorization at any time except to the extent that action has been taken on this authorization. I must do so in writing and present my written revocation to Lower Falls Pediatrics. I understand that authorizing the disclosure of this information is voluntary. This authorization expires 90 days from the date of the signature listed below. I have carefully read and understand the above and voluntary disclosure of the above information to those persons or agencies listed.

PARENT/Legal Rep Signature (17/younger) _____ Date _____

Patient Signature (18/older) _____ Date _____