AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Ste 201
Cohasset, MA 02025

Patient Name	Date of Birth	Telephone #
Street Address (Forwarding address if relocating)	City State	Zip

I hereby authorize the disclosure of information in my/my minor child's medical records

❑ to ❑ from: ❑ All providers at Child and Adolescent Health Specialists, PC
(check one) ❑ Only the specific providers listed:

_____

_____

❑ to ❑ from: Name: _____
(check one) Relationship to patient: ❑ Parent ❑ Physician ❑ Other _____
Address: _____

_____
Telephone #: _____ ❑ Mail (postage additional) ❑ Pick Up

Purpose of release: _____

If transferring care please list reason: _____

I authorize Child and Adolescent Health Specialists, PC to review or release a copy of my/my minor child's medical records including any sensitive medical information unless otherwise excluded below.*

I understand that Child and Adolescent Health Specialists, PC will not condition my treatment on whether I provide authorization for the requested use or disclosure unless the treatment is necessary for the purpose of creating protected health information for disclosure to a third party (e.g. physical exams for school, camp, employment, etc).

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

I understand that I may revoke this consent at any time by notifying Child and Adolescent Health Specialists, PC in writing. However, such revocation does not affect any actions taken by Child and Adolescent Health Specialists, PC before receiving my written notification. This request may take up to 30 days to process, during which time you will need to identify a new healthcare provider. We will continue to oversee healthcare for you/your child for 30 days from the date of this request, but not beyond that date.

There is a $26 processing fee per child for records to be sent from this office. Payment must accompany this form. Unpaid balances must be addressed. Please check one box below for copies of your child's records:

❑**General Medical Records** (will include: summary of your child's visits, copy of most recent health supervision exam, immunization record, growth charts, labs/x-rays and most recent specialist reports if pertinent).

❑ **Expanded Medical Records** (will include: General Medical Records plus additional reports and expanded problem-oriented visits). **You will be charged the $26 processing fee PLUS a per page charge of $.89 per page for the first 100 pages and $.45 per page for pages in excess of 100 pages, per Mass General Law S.B. 642.**

Medical record information will not be released or reviewed without a valid signature below. This authorization will expire 6 months from the signature date.

Signature: _____ Date: _____
(Parent/Legal guardian if a minor child)

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* I request that Child and Adolescent Health Specialists, PC release a copy of my/my minor child's medical records with the ***EXCLUSION*** of any reference to: (circle all that apply) drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment, or other protected information: (please specify) _____

Signature: _____ Date: _____
(Parent/Legal guardian if a minor child)