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Authorization For Use or Disclosure of Medical Record Information

Patient Information: ****Please Print****

Patient Full Name: _____ **Date of Birth:** _____

Email Address: _____ **Phone:** _____

Patient Address: _____ **City:** _____

State: _____ **Zip:** _____

Release Information To:
I hereby authorize Riverside Pediatrics to release my medical record information to:

☐ **Fax** ☐ **Mail Copies To:** ☐ **Hold for Pick up** ☐ **Discuss Medical Record Information With:**

Name/Facility: _____ **Attention:** _____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip:** _____ **Fax:** _____

Purpose of Request: ☐ **Personal** ☐ **Continuing Care (second opinion or refer to specialist)**
☐ **Insurance** ☐ **Legal** ☐ **Transfer Out of Riverside Pediatrics**

Information to be released:

☐ **Please provide a 2-year abstract of my medical information**
☐ **Please provide an abstract of my entire medical record**
☐ **Other-Please be specific** _____

Authorization to Release Protected Information: Required - Please complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Initial each line below to confirm your choices.

I ☐ **DO** ☐ **DO NOT** want *Psychiatric Treatment Notes released. _____
I ☐ **DO** ☐ **DO NOT** want information about *Sexually Transmitted Diseases released _____
I ☐ **DO** ☐ **DO NOT** want information about *HIV Tests & Related Information released _____
I ☐ **DO** ☐ **DO NOT** want information about *Alcohol and/or Substance Abuse released _____
I ☐ **DO** ☐ **DO NOT** want information about *Genetic Testing released _____
I ☐ **DO** ☐ **DO NOT** want information about _____ released
Other sensitive information?

_____ _____
Patient/Parent or Legally Recognized Representative Signature **Date**

Over →

(Records are sent within 30 days) **We will fax your records free of charge to your new provider if you provide us with their secure fax #.**

If you require a printed or mailed copy of your records, a processing fee of $15.00 is charged. **Payment must accompany this form.** Also, patient balances must be paid in full before we transfer any records.

Reason for leaving Riverside. _____

I am requesting records & care be transferred to another provider. I understand that as of the date of my signature, Riverside Pediatrics is unable to provide refills, referrals, or medical care.

****** You must notify your insurance company of the change in PCP.**

If paying by credit card, fill out the form below.

__ M/C __ Visa __ Discover __ Amex __ Check __ Cash

_____	_____	_____	_____
Card Number	CVV	Exp. Date	Amount

Signature _____ **Date**_____

If you are requesting a copy of your medical record from Riverside Pediatrics, we reserve the right to charge a reasonable cost-based fee for producing and mailing the copies, pursuant to HIPAA 45 CFR, 164.524. This rate depends on the size and delivery method of the records being requested. At no time will the cost-based fees exceed Massachusetts law (MGL Chapter 111; Section 70).