

Date: _____

AUTHORIZATION TO RELEASE INFORMATION

I, _____, authorize Hyde Park Pediatrics, P.C.
to release medical information and/or copies of medical records of
_____ Date of Birth _____

Please allow 5 business days for processing.

to:

Parent/Guardian

or to:

Name of physician/practice/hospital

Address

City, State, ZIP

This medical information includes the following types that we have in our possession. We will release records created at the practice, but not those from other practices or hospital inpatient records, which must be requested from the hospital.

- Office visit notes (To include all notes since 2006 and a summary of visits prior to that)
- Tests performed in the office or ordered by our providers
- Notes from consultants regarding visit or procedures and test results ordered by them
- Hospital ER notes and subsequent tests

As per Massachusetts and/or federal law:

Certain types of medical information are protected by law from release without specific consent and **will** not be released as a result of this authorization. If you **do not** want these records released, please check the appropriate box below:

- AIDS/HIV testing and results
- Mental health records
- Substance abuse (alcohol, narcotics, prescription drugs)
- Communications with social workers
- Sexually transmitted disease
- Domestic/child abuse records

****NOTE:** If your child is 18yrs or older (s)he must sign this form to receive their records

Printed Name / Relationship

Signature

Date

Reason for request: Age Moving Specialist Other _____