Pediatric Associates of Greater Salem
72 Highland Avenue
Salem, MA 01970
Phone: 978-745-3050
Fax: 978-745-7212

I.D. Verification (copy)
Driver's License _____
School I.D. _____
Professional License _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____ DOB _____
First Middle Last

ADDRESS _____ APT# ____ CITY _____ STATE ____ ZIP _____

SS# _____ PATIENT'S PHONE # _____

DATE OF REQUEST: _____ **DATE NEEDED**: _____

☐ I authorize **Pediatric Associates of Greater Salem to release information to or from**:

NAME OF AGENECY/PERSON _____

ADDRESS _____ APT# ____ CITY _____ STATE ____ ZIP _____

PURPOSE FOR THIS REQUEST: (Check one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one)

□ Immunization history
□ All medical records related to a specific illness or injury
□ Treatment summary (includes history/physical, laboratory tests and x-ray reports, operative reports, pathology)
□ Specific information (Select those that are applicable)
□ Procedure report □ History and physical □ Physical therapy □ Laboratory test results
□ X-ray reports □ Other (Please describe) _____

DISCLOSURE OF INFORMATION: Place your signature next to "Yes" or "No" for the following protected information to be released:

Drug/Alcohol Information	Yes _____	No _____
Mental Health, Including ADD/ADHD	Yes _____	No _____
AIDS/HIV Testing and Results	Yes _____	No _____
Sexually Transmitted Diseases, Testing and Results	Yes _____	No _____
Communicable Diseases	Yes _____	No _____

and is limited to the time period from _____ to _____

I understand that

- My right to healthcare is not conditioned on this authorization;
- I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance to my prior authorization;
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed again;
- There is a charge of $20.00 per child for the requested records, which can be picked up at the office or mailed for an additional fee of $5.00.

SIGNATURE OF PATIENT OR REPRESENTATIVE _____ DOB _____

RELATIONSHIP TO PATIENT (if requestor is not patient) _____