Brookline Pediatrics
Boston Children's
Primary Care Alliance

# REQUEST FOR MEDICAL RECORDS

PATIENT INFORMATION:

Patient's name:

Date of Birth:

Address:

Phone:

PREVIOUS PHYSICIAN TO RELEASE RECORDS:

RELEASE THE FOLLOWING INFORMATION:

____ Copy of all medical records (including records from prior providers and specialists)

____ Copy of all medical records from our practice ONLY

____ Immunization records

____ All diagnostic testing

____ Other (please specify) _____

____ I further authorize the disclosure of SENSITIVE and/or MEDICAL DATA including HIV, alcohol, psychiatric, and drug information, sexual assault or abuse, child abuse or neglect, sexually transmitted diseases, sexual preference, family interaction issues, regardless of source.

PLEASE RELEASE A COPY OF RECORDS TO:

Person/Company/Physician:

Address:

Phone: Fax:

_____

Signature of patient age 18 or older Signature of parent/legal representative (if minor)

*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
*I understand that the facility, its employees, and the physicians are released from any legal responsibility or liability for disclosure of the above information to the extent indicated in the authorized herein. *I understand that I may revoke this authorization at any time by giving written notice to your office. This authorization expires at age 18 if signed by legal representative (unless noted otherwise).
* If records need to be printed and either picked up or mailed, there will be a $25 charge.

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