MEDICAL RECORDS AUTHORIZATION

Receiving Records from Another Practice

Longwood Pediatrics
Boston Children's
Primary Care Alliance

longwoodpeds.com
617-277-7320 | *fax* 617-277-7834

Practice requesting records

Please mail or fax requested records here:

Longwood Pediatrics, LLP
ATTN: Medical Records
319 Longwood Avenue
Boston, MA 02115

Phone: 617-277-7320
Fax: 617-277-7834

* Please note that a patient may designate up to two (2) outside care providers to have permanent authorization to obtain copies of their medical records. This authorization may be revoked at any time upon your request. If you would like the above named care provider to have such access or update existing care providers, please choose one of the following:

❑ Please give the above named care provider authorization to my medical records

❑ Please replace
Existing authorization: _____
with the above named care provider

❑ Please remove the above named care provider's authorization.

The purpose or need for disclosure:

_____

Date range of information to be released:

From: _____

To: _____

Please check specific information to be released:

❑ Discharge summary
❑ History and physical
❑ Operative reports
❑ Outpatient progress notes
❑ Constitution Reports
❑ Pulmonary function tests
❑ Tissue exam reports
❑ Nuclear medicine reports
❑ Nuclear medicine CD images (bone scan, etc.)
❑ Heart diagnostics
❑ Radiology reports
❑ Radiology CD images (CT/x- ray, etc.)
❑ Lab results
❑ Other (please specify): _____

Practice releasing medical information

Patient information

Patient name: _____

Daytime phone: _____

Date of birth: _____

Authorization

Permission is hereby granted to the Longwood Pediatrics LLP to receive medical information from the individual/organization as identified above.

(Note: submission of this form authorizes the release of the information specified within one year from the date of signature.)

Patient/Authorized signature: _____

Print name: _____

Date: _____