HORIZON PEDIATRICS, INC.

Request for the Release of Medical Records from an Outside Provider

Patient: _____
(First Name) (Middle Name) (Last Name) (D.O.B.)

Address:_____

_____ is authorized to furnish to:
(Physician Name)

Horizon Pediatrics, Inc
Brian F Groden, MD
81 R Hawthorn Street
New Bedford, MA 02740
508-961-2403

MEDICAL RECORDS (Excluding Sensitive Information)

- Information and records or copies of records relating to the history, diagnosis,treatment or services rendered to me in connection with any condition or disease beginning _____and ending _____ and, if necessary, allow them or any physical appointment by them to examine any x-rays or records which the facility may have regarding my condition or treatment during this period

SENSITIVE INFORMATION

- I hereby specifically consent to the disclosure and release of highly confidential information: Information about HIV?AIDS status, information about genetic testing, information related to confidential communication with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional, information about treatment of substance abuse (alcohol or drug), information about venereal disease(s), abortion consent form(s), mammography records, information about family planning services, if I an emancipated minor, information about treatment and diagnosis (except to my parents), information about research involving controlled substances.

I release Horizon Pediatrics and Brian Groden, MD from all responsibility or liability that may arise from this authorization. I may withdraw this consent by giving written notification to Horizon Pediatrics and Brian Groden, MD at any time prior to the disclosure or release of information.

_____ _____
Patient Signature (Parent if minor) Date

_____ _____
Witness Signature Date