BRAMBLEBUSH PEDIATRICS

Authorization for Release of Information

By signing this form, I authorize you to release a copy of my medical records to the person or entity listed below.

NAME ______________________________ DATE OF BIRTH ________________

ADDRESS ______________________________ PHONE ________________________

CITY ___________________________ STATE ______ ZIP __________________

I hereby authorize:

FORMER PHYSICIAN: __________________________________

Address: __________________________________

____

Phone: __________________________________

To release copies of my medical record to:

Name: ____**BRAMBLE BUSH PEDIATRICS** ______________

Address: ____**15 BRAMBLEBUSH PARK** _________________

____**FALMOUTH MA 02540**____________________

This authorization shall remain in effect for 90 days unless specifically revoked in writing.

Signature of patient or legal representative: ________________________ Date __________

Relationship to patient: ____________________________

Sensitive Information Authorization: Separate authorization is required to release sensitive information such as abortion, substance abuse, genetic information, mental health notes sexually transmitted diseases, rape or abuse.

Signature of patient or legal representative: ________________________ Date __________

HIV/AIDS Information Authorization: Specific authorization is required for and HIV related information.

Signature of patient or legal representative: ________________________ Date __________