Pediatricians, Inc.
Comprehensive and personalized pediatric care.

955 Main Street
Suite 103 & 106
Winchester, MA 01890
PH: (781) 729-4262
FAX: (781) 729-0692

MEDICAL RELEASE FORM

Date:_____

Patient:_____**DOB:**_____

Address:_____

Phone:_____

Because records may contain sensitive information, we may ask you to sign and return the enclosed Authorization for Release of Medical information.

There is a fee of $20.00 for each medical record transferred. The fee is expected prior to release of records.

Checks should be payable to: Pediatricians, Inc.

If you insist on records on off -site storage, there is an additional charge of $20.00 to cover the cost of retrieving the record.

Please Note: Medical records cannot be copied upon demand. The normal completion time is 5-7 business days. Your record will be placed in long-term storage for 7-10 years. After that time, it may not be available. We suggest you make a copy of any pertinent information, I.e Immunizations, for your personal records.

If you have any questions about this form or the request, please call at (781) 729-4262.

Reason for Request-(transfer of care, specialist appt,etc.)_____

Any specific information to be released & dates of care included:_____

_____

Method of Medical Transfer: ____ **Pick-Up** ____ **Mail**

If Mailing:

Name:_____

Address:_____

_____

_____

MEDICAL RELEASE FORM CONTINUED...

If patient is 18 years old and the medical record is going to be picked up by someone else the patient must sign below to release thier records.
Patient's Signature:_____
Please list names of people who you allow to pick up your records:

_____
_____

Please have my physician send the following information: (mark all that apply)

_____ Complete record **_____ X-Rays**
_____ Progress Notes **_____ Well Visit**
_____ Labs **_____ Shot Record**
_____ Specific dates of treatment: _____ to_____
Other:_____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

Patients Signature:_____
Parent/Guardian Signature:_____

I understand that my medical record contains information in reference to drug and or Alcohol abuse, Psychiatric, Venereal disease, Social service, Hep B Testing/ Treatment, and/or sensitive information, I agree to its release.

Patients Signature:_____
Parent/Guardian Signature:_____
Date:_____

In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released you must sign and date the line below.
*** I agree to the release of this information.**

Patient's Signature:_____
Parent/Guardian Signature:_____
