OAK Pediatrics, LLC
198 Littleton Rd # 204
Westford, MA 01886
Phone: 978-746-6382
Fax: 978-218-8660

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name:_____Date of Birth:_____

Address: _____

Home Phone:_____Cell Phone: _____

Release Information: I hereby authorize OAK Pediatrics to
Release my medical records to: [ ] Obtain my medical records from: [ ]

Name/Facility:_____Phone: _____

Address:_____Fax: _____

City:_____State:_____Zip Code: _____

Purpose of request: [ ] Personal [ ] Continuing care (referral/2nd opinion) [ ] Legal [ ] other

[ ] Transfer of care (new primary care physician), if transferring, please explain: _____

_____

Information to be released: (Please contact the office for information regarding fees for copying records)

[ ] Entire record [ ] Other_____

[ ] Abstract (Includes chart summary, immunization report, last 2 years of office visits & labs from last date seen and 5 years of diagnostic reports and consults from date on release form)

This authorization is valid until_____or if not specified for 180 days and maybe revoked at any time in writing prior to the expiration date. An additional authorization for re-disclosure beyond recipient is required.

Patient's/Guardian Signature: Date: _____

_____

Witness Signature: Date: _____

_____

(NOT VALID UNLESS WITNESSED)

I understand that if my medical record contains information relating to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, I would like information relating to HIV/AIDS testing/treatment and/or sensitive information will be released by signing:

Patient's/Guardian Signature: Date: _____

_____

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