FAIRVIEW PEDIATRICS, LLC

1176 Memorial Drive, Chicopee, MA 01020 Phone: (413)593-1333 Fax: (413)593-1444 Web: www.fairviewpeds.com

James Bell MD • Hanna Awkal MD • Thomas Wadzinski MD,PhD • Erica Madara MSN, FNP-BC

AUTHORIZATION TO REQUEST / RELEASE MEDICAL RECORDS

Patient Information

Patient Name: _____ **Date of Birth:** _____

Address: _____

Home Phone: _____ **Cell Phone:** _____

1. Request for information FROM ANOTHER ENTITY / OFFICE:

I give consent to release information **TO Fairview Pediatrics** from the medical/treatment record (including psychiatric and/or substance abuse information if applicable) maintained for the patient named above while he/she was a patient at:

_____

_____.

**** Please provide the complete name, address, phone, and fax information for the entity to which records are to be released****

☐ **I understand that:**
Once records from a patient's prior PCP are received by Fairview Pediatrics, they will be scanned into the patient's chart and the parent/guardian will be notified that they have 30 days to pick up the records if they wish. Any records not picked up after 30 days will be destroyed. The scanned records will not be released to the patient if the patient transfers to another PCP.

2. Release of Information FROM FAIRVIEW PEDIATRICS:

I give consent to release information from the medical record of the patient named above for the time period of:

_____.

If entire record is to be released, write "All records."

If records are to be released from Fairview Pediatrics (please choose one):

☐ **Legal Record Set:** Includes records generated by Fairview Pediatrics only. Does not include records generated by any other entity, such as other doctors' offices, hospitals, or laboratories.

☐ **Designated Record Set:** Includes all records maintained by Fairview Pediatrics, including both records generated by Fairview Pediatrics and records generated by other entities. Please be aware that Fairview Pediatrics cannot attest to the accuracy or completeness of records generated by other entities. This release does not include records from any prior Primary Care Providers.

Reason you are leaving the practice? (If applicable) _____

Other Information To Be Released:

☐ **Release of Sensitive Information:** I understand that if the medical record of the patient named above contains information in reference to drug and/or alcohol abuse, psychiatric care, venereal disease, social service, Hepatitis B testing, and/or other sensitive information, I agree to its release.

_____ _____
Signature of Patient or Legal Guardian Date Form Signed

☐ **Release of HIV Information:** I understand that if the medical record of the patient named above contains information in reference to HIV / AIDS testing, I agree to its release.

_____ _____
Signature of Patient or Legal Guardian Date Form Signed

If the entire record is not to be released, the specific information to be disclosed is: (check all that apply)

☐ **Immunization Records**
☐ **Form for Camp, School, or Sports**
☐ **Laboratory Results**
☐ **Radiology Results**
☐ **Attorney Information**
☐ **Office Notes**
☐ **Other: (please specify)**
_____
_____