Bass River Pediatric Associates

Authorization for Disclosure of Medical Record Information

INCOMING RECORDS

Instructions: Please complete, sign and **return to the facility you are requesting records from.**

Patient name: _____ Patient Date of Birth_____

Patient Address: _____

Street City/Town State Zip Code

I hereby authorize and request: _____

Name of doctor or facility

Address of doctor or facility Phone # Fax #

To release a copy of my medical records to: **Bass River Pediatric Associates** by one of the following methods:

1. Mail to 237 Station Avenue, South Yarmouth, MA 02664 or
2. Fax to 508-760-1919

PLEASE- NO DISCS

For the purpose of: Personal__ Insurance__ Legal__ Other___ *Changing doctor___

Requested information: _____

Please include only the last 3 years of records and any additional history that would be relevant to the current treatment plan. Include problem list, medication list, immunizations, office visits, labs, diagnostic imaging reports.

Covering the period from: _____ to: _____

I am aware that the record to be disclosed pursuant to this Authorization may contain the following subject matter and I am authorizing the release of such highly sensitive information:

- **-Alcohol/Drug use, abuse and/or treatment**
- **-Treatment for mental illness and/or social services communications**
- **-History of venereal or other communicable disease(s)**
- **-Treatment or testing for HIV/AIDS**

However, I am requesting that the following information be excluded from the release:

Patient or Legal Representative Name (print):_____

Patient or legal Representative Signature:_____Date:_____

Relationship to patient if signing for them _____

Patient or legal representative E-mail address_____

For questions please contact Bass River Pediatric Associates

Phone 508-394-2116

This authorization is good for 12 months from the date signed.