Bramblebush Pediatrics
Boston Children's
Primary Care Alliance

if Patient is over 18 years of age they must complete form

Authorization to disclose protected health information

Patient name:_____ DOB:_____

RECORDS RELEASED FROM: **Date:**_____

Name: Bramblebush Pediatrics

Address: 15 Bramblebush Park

City/State/Zip code: Falmouth MA. 02540

Telephone: 508-548-6969 Fax: 617-730-7996

RECORDS TO BE SENT TO:

Name:_____

Address:_____

City/State/Zip code:_____

Telephone:_____ Fax:_____

REASON or PURPOSE(please check which applies)

____transfer of care ____ relocating ____ per patient request

____ Insurance ____School ____ Legal ____ Other

TYPE OF INFORMATION TO BE DISCLOSED:

____whole medical record ____partial record (please specify) _____

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR 90 DAYS UNLESS SPECIFICALLY REVOKED IN WRITING

X_____ Date:_____ Relationship_____

signature of Patient, Parent, or Legal Guardian (if not patient)

Sensitive information release: separate authorization is required to relase sensitive information such as abortion, substance abuse, genetic information, mental health notes, sexually transmitted diseases, rape, abuse HIV/AIDS.

X_____ Date:_____ Relationship_____

signature of Patient, Parent, or Legal Guardian (if not patient)

PLEASE BE AWARE OF $20 COPYING FEE FOR RECORDS