WESTON
pediatric
PHYSICIANS

486 Boston Post Road, Weston, MA 02493

781.899.4456 phone
781.647.9578 fax

Authorization To Release Information

I, _____, authorize Weston Pediatric Physicians, P.C. to release medical information and/or copies of medical records of (please include date of birth) _____ to:

_____ or to:
Parent/Guardian

_____
Name of Physician/practice/hospital

_____
Address

_____
City, State, Zip

This medical information includes the following types that we have in our possession. We will release records created at the practice as well as copies of records from previous practices or hospital inpatient records, per your request.

Office visit notes, hospital ER notes, and subsequent visits, tests performed in the office or ordered by our providers, and notes from consultants regarding visits/procedures and results of tests ordered by them

As per Massachusetts and/or Federal Law certain types of medical information is protected by law from release without specific consent, and will not be released as a result of this authorization. If you DO NOT want these records released, please check the appropriate box below:

☐ AIDS/HIV testing and results
☐ Mental Health records and references
☐ Substance abuse (alcohol, narcotics, prescription drugs)
☐ Communications with social workers
☐ Sexually transmitted diseases
☐ Domestic abuse records

There is a $25 fee for copies of records. Once we receive your payment, we will process your request. Please check one of the boxes below *(allow 2-4 weeks)* and include a number where you can be reached _____:

☐ Transfer patient out of Weston Pediatric Physicians, P.C. ☐ mail ☐ pickup
☐ Please forward a copy of the record for my personal records ☐ mail ☐ pickup

☐ Please forward copies of visits pertinent to my specialty care visit – no charge

Your reason for transferring from Weston Pediatrics Physicians, P.C.:

_____

Signed: _____ _____
Parent or Guardian of Child Under 18 Years of Age — Date

Signed: _____ _____
Patient 18 Years of Age or Older — Date