AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

MILL BROOK PEDIATRICS, PC
490 Boston Post Road – Suite 2002
Sudbury, MA 01776
Ph.978-443-0707 Fx.978-440-9389

PATIENT RECORD RELEASE

Patient Name: _____DOB:_____Today's Date_____

In the event that we may need to contact you, please leave a forwarding address:

_____

INFORMATION TO BE RELEASED: Choose one

[ ] Medical Summary – Includes a Chart Summary, Massachusetts School Health Record and Immunization Record, growth charts and most recent physical exam. **Provided at no charge.**

- ☐ Will pick up
- ☐ Mail or fax to: _____

[ ] Entire Medical Record - Fees may apply.

[ ] Specific Records – Please check all that apply and note date range in space provided. **Fees may apply**.

Please check one:

- ☐ Physicians Notes_____
- ☐ Lab results_____
- ☐ Other (specify)_____
  - ○ Will pick up
  - ○ Mail or fax to:_____

Please check one:

- ○ Transfer to Adult MD(change PCP with insurance company)
- ○ Moving (date of move) _____
- ○ Insurance change
- ○ Other _____
- ○ Transferring all care to new physician (please indicate reason for leaving) change PCP with insurance company

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By signing this authorization, I hereby authorize Mill Brook Pediatrics, PC to release health information including copies of my/my child's medical records to the following person(s) or facilities at the locations listed for the purposed described.

Signature_____ Phone #_____