Brockton Pediatrics, Inc. 65 Libby Street, Brockton, Mass. 02302

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name_____ **Date of Birth**_____

Patient Address_____**Telephone**_____

City, State, Zip Code_____ **Social Sec. No.**_____

I hereby authorize,(name of former Pediatritian):_____

Or facility:_____

Address:

_____**City**_____**State**_____**Zip**_____

To release including those portions of my medical records, which may?

- ✓ Pertain to the identity, diagnosis, prognosis or treatment of alcohol or drug abuse
- ✓ Relate to venereal disease
- ✓ Communication between myself and psychotherapists relative to the diagnosis or Treatment of my mental or emotional condition
- ✓ Contain information concerning any testing for the presence of HIV antibody or Antigen

My medical records are to be released to:

BROCKTON PEDIATRICS, INC.
65 LIBBY STREET
BROCKTON MA, 02302

This information will not be given, sold, transferred, or relayed to any other person not specified in this authorization without first obtaining my written consent, which states the need for the proposed new use of this information or the need for its being transferred to another person. This authorization may be withdrawn at any future time. This authorization will expire in 90 days from date of signature.

_____ _____

Signature of patient (or parent/legal guardian) **Date**

Brockton Pediatrics, Inc. 65 Libby Street Brockton, Mass. 02302

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name_____ **Date of Birth**_____

Patient Address_____ **Telephone**_____

City,State,Zip code_____ **Social Security no.**_____

Hereby authorize Brockton Pediatrics, Inc. to furnish any and all healthcare information concerning my treatment.
Including those portions of my medical records, which may:

- **Pertain to the identity, diagnosis, prognosis or treatment of alcohol or drug abuse**
- **Relate to venereal disease**
- **Communication between myself and psychotherapists relative to the diagnosis or treatment of my mental or emotional condition**
- **Contain information concerning any testing for the presence of HIV antibody or antigen**

My medical records are to be released to:

_____
(person or doctor you wish records sent)

_____
(Address, including city, state, and zip code)

This information will not be given, sold, transferred, or relayed to any other person not specified in this authorization without first obtaining my written consent, which states the need for the proposed new use of this information or the need for its being transferred to another person. This authorization may be withdrawn at any future time. This authorization will expire in 90 days from date of signature.

_____ _____
Signature of patient (or parent/legal guardian) **Date**

_____
Witness signature