

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 This authorization may be withdrawn at any future time.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