Authorization for Release of Medical Information

Release Information from:

Start Line Pediatrics, LLC
77 West Main Street, Suite 201
Hopkinton, MA 01748
Phone: 508-435-7100, Fax: 508-435-7110

Today's Date: _____________________

Patient Name: ____ Patient DOB: _____________________

Address: ____

Phone Number: _______________________________

Release Information to:

Name: ____

Address: ____

____

Reason for leaving Start Line Pediatrics: ____

I understand that:

• I may inspect or copy the protected health information to be used or disclosed
• I may revoke this authorization in writing by contacting your office
• Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA

Authorization:

SENSITIVE INFORMATION RELEASE AUTHORIZATION (please circle answer for each situation): I understand that if the above named patient's medical record contains information pertaining to conditions listed below, then I specifically authorize release of that information to be included in this medical record release.

YES NO Treatment for alcoholism / substance abuse.
YES NO Treatment for mental health illnesses / communication with mental health specialists.
YES NO Information related to sexually / venereal transmitted disease.
YES NO Treatment for HIV / AIDS

I authorize Start Line Pediatrics to release the above named patient's medical record to the above named person / facility. This authorization shall remain in effect for 30 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 and / or the legal representative presents legal proof of representation.

________ ___________________________________ _______________________________
Date Signature of patient or legal representative Name / Relation to patient