Smithfield Pediatrics
7 Smith Avenue, Suite 103, Greenville, RI 02828
Phone 231-3138

Authorization to obtain/release medical records & health care information

1.PATIENT INFORMATION:
Name: ______________________________ Date of Birth: ___________ Phone:_______________
Address: ______________________________ City: ___________________State:____ Zip:______

2.I hereby authorize Smithfield Pediatrics to ____OBTAIN FROM **OR** ____RELEASE TO: (check one)
Name:____Phone Number:_______________________
Address:____________________________________Fax Number:__________________________
City:__________________________State: Zip:__________________

3.Which of the following information do you WANT *to* be released? (check *all* that *apply)*
___ ALL medical records ___ History and Physical ____Progress Notes ___ Lab results
___Radiology reports ___ Immunization records ____ other (specify)_____________________

4.SENSITIVE INFORMATION*:* The following information is NOT to be released: (check *all* that apply)
___ Mental Health Notes ___ Substance Abuse Treatment Notes
___ Sexually Transmitted Diseases ___ Other (specify)_________________________________

5.Purpose: Tell us what this record request is for: (check one)
___Legal Matter ____Insurance ____Treatment by a specialist ____Coordination of Care
__ Transfer of care to another healthcare provider:
May we *ask why* you are leaving? ___Moving ___Change of Insurance
___Dissatisfied with service provided (please explain),_________________________________
__ other *(please* explain)____

SIGN THE AUTHORIZATION STATEMENT BELOW:
I understand that I may revoke my authorization in writing any time by notifying Smithfield Pediatrics. I understand that any previously disclosed information would not be subject to the revocation request. Unless otherwise revoked, this authorization will expire 1 year from the date signed below. I understand that my records cannot be disclosed without my written authorization except *as* otherwise specifically provided by law. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by Federal HIPAA Privacy Rules. I have the right to refuse to sign this authorization and my refusal to sign will not affect my ability to obtain treatment.

Signature of Legal Guardian:____
Relationship to Patient:____________________________Date:____________________