

Smithfield Pediatrics
7 Smith Avenue, Suite 103, Greenville, RI 02828
Phone 231-3138 Fax 231-4757

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

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 ninety (90) days 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: _____