Smithfield Pediatrics
7 Smith Ave, Suite 103, Greenville, RI 02828
Ph: 401-231-3138 Fax: 401-231-4757

Medical records request Process and Fees

The Office of Smithfield Pediatrics will provide your child(ren) records for you once you have completed the Patient Authorization for use/Disclosure of Protected health Information (PHI) form (Medical Release form). You can find this form on our website or you can contact our office and we can mail or fax one to you. Please be sure to sign the form. Unsigned requests cannot be processed.

Please be aware if your child is 18 years old or older, they will need to fill out the form and sign it *themselves**.

There is a $25 processing fee for copying medical records, this will be due prior to processing of records.

Once we have received the signed release and fee, your request will be processed and fulfilled within 30 business days. We will either mail or fax the records (depending on size of records), to the information you provide on the authorization form.

Smithfield Pediatrics

7 Smith Ave, Suite 103, Greenville, RI 02828
Ph: 401-231-3138 Fax: 401-231-4757

Authorization to obtain/release Medical Records & health care information

PATIENT INFORMATION:

Name: _____ **Date of Birth**: _____**Phone**:_____

Address: _____**City**: _____**State**:____**Zip**:_____

I hereby authorize Smithfield Pediatrics to (check one) ___ OBTAIN FROM ***OR*** __ RELEASE TO:

Name:_____Phone Number:_____
Address:_____Fax Number: _____
City: _____State: _____Zip: _____

1.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)_____

2.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)_____

3.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)_____

ACKNOWLEDGE 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/Patient (if 16 years or older): _____
Relationship to Patient:_____Date:_____

PLEASE BE AWARE THAT THERE IS A $25 FEE FOR PROCESSING RECORDS TO BE COLLECTED PRIOR TO PROCESSING.