Authorization for Release of Medical Information

Please complete form thoroughly. Your medical records cannot be released to us until this form is completed, signed by the patient or legal guardian and returned to Marblehead Pediatrics. As you complete each step on the form, please check the box provided at left.

Please Print Neatly!

Step 1 Completed ☐	**Step 1: Information about you:** Patient Name: _____ Last First Date of Birth: _____ Address: _____ _____
Step 2 Completed ☐	**Step 2: Who has the records now?** I hereby authorize: _____ M.D./D.M.D. (circle) Name Address: _____ _____ _____
Step 3 Completed ☐	**Step 3: To release the following information (please specify):** ☐ All Records ☐ Dates of Treatment _____ to _____ ☐ Other_____ To: Marblehead Pediatrics 70 Atlantic Avenue Marblehead, MA 01945
Step 4 Completed ☐	**Step 4: Your signature:** This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required. _____ Patient's Signature Date _____ Parent/Guardian's Signature Date
Step 5 Completed ☐	**Step 5: Release for Sensitive Information:** I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, hepatitis B testing/treatment, and/or sensitive information, I agree to its release. _____ Signature of Patient or Legal Guardian Date
Step 6 Completed ☐	**Step 6: Release of HIV Information:** In addition to the above signatures, if you want your HIV (AIDS) testing/treatment records released you must sign and date on the line below. I agree to the release of this information. _____ Signature of Patient or Legal Guardian Date