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Easthampton MA 01027

HAMPSHIRE PEDIATRICS

Office **413 - 529 - 0600**
Fax **413 - 529 - 1919**

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Legal Name: _____

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

Provider Information (To be sent by)

Name: _____

Address: _____

_____

Request Information (To be sent to)

Name: _____

Address: _____

_____

Please release the following information:

- ☐ **Last physical exam**
- ☐ **Immunization record**
- ☐ **Entire record**
- ☐ **Other (please specify):** _____

In accordance with federal regulations, I hereby consent to the release of records pertaining to treatment/diagnosis of the following should records contain this information: conditions relating to drug and/or alcohol abuse, psychiatric/psychological treatment, AIDS/HIV and communicable diseases.

I understand that I may revoke this authorization at any time except to the extent that action based on this authorization has already been taken.

_____ _____

Signature (Parent or Legal Guardian) **Date**

_____

Relationship to Patient