GREATER LOWELL PEDIATRICS, INC.

HEALTH CARE FOR INFANTS, CHILDREN, AND ADOLESCENTS

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

_____ **Transferring In Patient** ⇦ **Please Check** ⇨ _____ **Transferring Out Patient**

Patient Last Name _____ First Name _____ MI_____

Patient D.O.B. _____ Patient Address _____

Cell Phone #: _____ Home Phone #: _____

**Authorization:** I _____authorize **Greater Lowell Pediatrics, Inc.** to
**(Print: Parent/Guardian or Patient 18+ yr.)**
release my/child's:

_____ Complete Medical Record

_____ Only the Following Specific Information: _____

_____

From/To: _____
Name of Practice/Provider Full Address

Office Main Telephone Number: _____ Office Fax Number: _____

**Please Note: There is a $15.00 non-refundable RETAINER FEE per COMPLETE RECORD at time of request payable by Cash or Credit/Debit card ONLY (NO CHECKS). Records will cost .50 cents per page and not to exceed $50.00 per record.**
**(This includes Medicaid/Medicare Patients).**

**Please Indicate Reason for Request:**

_____ Leaving GLP – Insurance Change, Please List New Insurance _____
_____ Leaving GLP – Change of Primary Care Physician
_____ Leaving GLP – Dissatisfied, Please Explain _____
_____ Copy of Record for Personal Use
_____ Other: Please Specify _____

**Release of Sensitive Information:**

I understand that if my medical records contain sensitive related information to drug and/or alcohol abuse, mental health visits, sexually transmitted disease, social service, infertility, abortion, child abuse, sexual abuse, assault, rape and sexual transmitted disease, Hepatitis, HIV/AIDS, I elect the following:

_____ I AGREE to the release of the Information _____ I DO NOT AGREE to the release of this Information _____ N/A

_____ _____
Signature: (Name of Parent/Guardian/Patient 18+ yr.) (Date)