

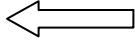


GREATER LOWELL PEDIATRICS, INC.

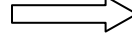
HEALTH CARE FOR INFANTS, CHILDREN, AND ADOLESCENTS

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)