

**AUTHORIZATION FOR RELEASE OF
MEDICAL INFORMATION**

MILL BROOK PEDIATRICS, PC
490 Boston Post Road – Suite 2002
Sudbury, MA 01776
Ph.978-443-0707 Fx.978-440-9389



PATIENT RECORD RELEASE

Patient Name: _____ DOB: _____ Today's Date _____

In the event that we may need to contact you, please leave a forwarding address:

INFORMATION TO BE RELEASED: Choose one

Medical Summary – Includes a Chart Summary, Massachusetts School Health Record and Immunization Record, growth charts and most recent physical exam. **Provided at no charge.**

Will pick up

Mail or fax to: _____

Entire Medical Record - Fees may apply.

Specific Records – Please check all that apply and note date range in space provided. **Fees may apply.**

Please check one:

Physicians Notes _____

Lab results _____

Other (specify) _____

Will pick up

Mail or fax to: _____

Please check one:

Transfer to Adult MD (change PCP with insurance company)

Moving (date of move) _____

Insurance change

Other _____

Transferring all care to new physician (please indicate reason for leaving) change PCP with insurance company

By signing this authorization, I hereby authorize Mill Brook Pediatrics, PC to release health information including copies of my/my child's medical records to the following person(s) or facilities at the locations listed for the purposes described.

Signature _____ Phone # _____