Signed form may be faxed to: 508-747-1147,
or mailed to: Performance Pediatrics,
23 Aldrin Road, Plymouth, MA 02360

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Incomplete forms and forms without payment (if indicated) will not be honored.

If you have questions related to this form, contact Performance Pediatrics at 508-747-8277.

In accordance with Massachusetts Medical Society guidelines, patients are entitled to receive a copy of their medical record upon request (practices have 30 days to comply). Physicians can charge for the cost of copying and providing medical records, but Massachusetts law states that the rate must be reasonable. The state defines a reasonable rate as no more than the following and these are Performance Pediatrics' rates:

- A base fee of $15 per request
- Fifty cents ($0.50) per page for the first 100 pages, and $0.25 per page for every page after 100

PURPOSE OF RELEASE (check the appropriate box below):

NO CHARGE	Minimum Payment of $15 Must Accompany Form
One-time Transfer Summary (to parent)	Insurance
Medical Care (to MD only)	Personal
	Legal Matter
	Other (please specify):_____

All copying charges must be paid in full prior to our releasing records.

Patient Demographics

Last Name _____ First Name_____ MI_____

Home Mailing Address_____

City_____ State_____Zip_____

Preferred Telephone_____ Alternate Telephone _____ Date of Birth_____

I authorize Performance Pediatrics to release my/my child's protected health information including medical record of care to the following person(s) at the address/facility listed below:

Name/Facility_____

Attention_____ Telephone_____

Address_____ Fax_____

City/State_____ Zip_____

FORMAT OF RELEASE (please check appropriate box below):

Electronic (unprotected CD or Flash Drive)
Paper
Fax (to MD Office only)

INFORMATION REQUESTED:

Date Range for information needed: _____

Entire Medical Record (charges apply)
Medical Record Abstract (perfect for transfer to new provider)
Other: _____

Performance Pediatrics has my permission to release information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child's medical record):

PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED

	HIV Test Results (Specific Patient Authorization Required For Each Release Request) Specify Dates:
	Genetic Screening Test Results (Specify Type of Test):
	Alcohol and Drug Abuse Treatment Records Protected by Federal Confidentiality Rule 42 CFR Part 2 FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURES IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART2. I can, however, cancel this authorization in writing at any time, except to the extent that Performance Pediatrics has relied upon it.
	Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC). I understand that my permission may not be required to release my mental health records for payment purposes.
	Confidential Communications with a Licensed Social Worker
	Information related to a sexually transmitted disease
	Information related to diagnosis or treatment of Hepatitis
	Information related to diagnosis or treatment of Pregnancy
	Information related to spouse abuse and/or child abuse or neglect
	Information concerning family violence and/or Domestic Violence Victims' Counseling
	Contain information regarding rape and/or Sexual Assault Counseling
	Other(s): Please list

I hereby authorize Performance Pediatrics to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Performance Pediatrics cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Performance Pediatrics may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the signature date, unless otherwise specified. I can, however, cancel this authorization in writing at any time, except to the extent that Performance Pediatrics has relied upon it. For example if I cancel it after Performance Pediatrics has sent the requested records, Performance Pediatrics will not retrieve those records. Instructions for canceling this authorization are included in the Performance Pediatrics Notice of Privacy Practices.

I understand that Performance Pediatrics will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.

Signature of Patient_____ Name of Patient (please print) _____Date_____

Signature of Parent or Guardian_____ Relationship to Patient_____ Date_____