Singular Pediatrics
32 Union Street
Newton Centre, MA 02459
Phone: 617-209-3933
Fax: 857-404-0581

L.D Verification (copy)
Driver's License: ______________________
School I.D: __________________________
Professional License:__________________

AUTHORIZATION TO RELEASE and/or RECEIVE HEALTH INFORMATION

PATIENT NAME ____ DOB____/ ____/______
First Middle Last
ADDRESS____________________________CITY___________________________STATE_______ZIP______
PATIENT'S PHONE #___________________________

I authorize Singular Pediatrics to release information to and/or receive information from:
NAME OF AGENCY/PERSON/PROVIDER/PRACTICE ____
ADDRESS____________________________CITY___________________________STATE_______ZIP______

PURPOSE FOR THIS REQUEST: (Check one)
____Healthcare ____Insurance Coverage ____Transfer of Care ____Personal ____Legal
TYPE OF RECORDS REQUESTED: (Check one)
____Copy of entire medical record as allowed by law
____Immunization history
____Billing records
____All medical records related to a specific illness or injury:_____________________________________
____Treatment summary (includes history/physical, laboratory tests and x-ray reports, operative reports, pathology)
____Specific information (select those that are applicable)
____Procedure Report ____History and Physical ____Physical Therapy
____Laboratory Test Results ____X-ray Reports
____Other:____

SENSITIVE INFORMATION: Please read carefully. By law, if you want us to release any of the following information from your record, you must sign below. Please place your initials next to 'Yes' or 'No.'

Drug/Alcohol Information	Yes________	No________
Mental Health, including ADD/ADHD	Yes________	No________
AIDS/HIV Testing and Results	Yes________	No________
Sexually Transmitted Diseases, Testing and Results	Yes________	No________
Communicable Diseases	Yes________	No________

And this is limited to the time period from ______________________to____________________________

I understand that:

- My right to healthcare is not conditioned to this authorization;
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in response to my prior authorization;
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be disclosed again;
- There may be a charge per child for the requested records, which can be picked up at the office or mailed for an additional fee.

SIGNATURE OF PATIENT OR REPRESENTATIVE________________________________**DATE**____________

RELATIONSHIP TO PATIENT (If requestor is not the patient)_____________________________________