Pediatrics Associates

450 Veterans Memorial Parkway, Building 10, E Prov., RI 02914 (401) 438-6888

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Street Address: _____Telephone:_____

City, State, Zip: _____

Records request to be ___ received from ___ sent to ___ verbal exchange

Physician/Facility: _____

Street Address:_____

City, State, Zip: _____

Please release the following information (check one):

___ All records, including those pertaining to substance abuse or HIV and AIDS, if applicable

___ All records, not including those pertaining to substance abuse or HIV and AIDS, if applicable

___ Immunization records only

Records Format: _____ Paper copies _____ Electronic records on a CD _____ Fax

***Note**: If the patient is a minor, the parent or guardian must sign. If the patient is an adult and does not sign this consent form, the party signing must provide legal documentation providing their authority to do so. This information will not be given, sold, transferred, or delayed to any other person not specified in this authorization without first obtaining my written consent, which states the need for the proposed new use of this information, or the need for its being transferred to another person.*

Print Name: _____ Relationship: _____

Signature: _____ Date: _____