Authorization for Release of Medical Record Information

Use Plate or Print:

MRN#:

DOB:

Pt Name:

Gender:

To request release of medical information please complete and sign this form and return it to:

Medical Records Department
Children's Hospital Boston
300 Longwood Avenue
Boston MA 02115

You may submit this form by Fax to: 617-730-0329

If you need help completing this form, please contact the Medical Records Services Department at 617-355-7546.

Patient Information

Patient Last Name		**First Name**		**MI**	
Street Address				**Apt#**	
City		**State**		**Zip**	
Children's MR#		**Home Telephone**	( )		
Date of Birth		**Alternate Telephone**	( )		

Children's Hospital has my permission to release information contained in the Medical Record of the above named patient.

Information Requested (please be specific and enter date of service if known):

Restrictions and/or Exclusions (if any):

Purpose of Release:

Children's Hospital will provide the information requested above to the following party:

Name			
Attention of		**Telephone**	
Street Address		**Suite/Room**	
City	**State**		**Zip**

I hereby authorize Children's Hospital Boston (Children's) 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 Children's cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Children's 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. I can however, cancel this authorization in writing at any time, except to the extent that Children's has relied upon it. For example, if I cancel it after Children's has sent requested records, Children's will not retrieve those records. Instructions for canceling this authorization are included in the Children's Notice of Privacy Practices.

I understand that Children's will continue to provide care, even if I do not authorize this release.

Signature of Patient (if 18 years of age or older)		**Date**
Signature of Parent or Guardian (if minor patient)	**Relationship to Patient**	**Date**

Please make a copy of this release for your records.