BROCKTON PEDIATRICS, INC.
65 LIBBY STREET
BROCKTON, MA 02302
Phone: 508-584-6060
Fax: 508-584-4949

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____PHONE:_____

PREVIOUS PHYSICIAN INFORMATION:

Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

REASON FOR RELEASE: ( ) Transfer of records

Please release **ALL** Medical Records including:

*Progress Notes *Labs/X-rays *ER Records *Psychiatric diagnosis and/or treatment *Specialists Records *Alcohol and/or Drug abuse *Sexual abuse/Rape *Sexually Transmitted diseases *Immunization Records *HIV testing,results and/or treatment *Abortion, genetic testing and /or treatment

RELEASE TO:

BROCKTON PEDIATRICS, INC.
65 LIBBY STREET
BROCKTON, MA 02302

_____ _____
Patient, Parent, Guardian Signature Date

**This authorization will remain in effect for 90days after the above date or as specified:
I understand that I may revoke this authorization at any time by providing the Medical Record Department with a written revocation, and that the revocation will be honored except to the extent that this authorization has been acted upon.