

Authorization for Release of Medical Records



Greater Lowell Pediatrics
Boston Children's
Primary Care Alliance

greaterlowellpediatrics.com
Lowell: 978-452-2200 | fax 978-441-2550
Westford: 978-392-2200 | fax 978-392-8500

Patient transferring in Patient transferring out

Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell phone: _____ Other phone: _____

Records transfer

From another practice/provider **to Greater Lowell Pediatrics**

From Greater Lowell Pediatrics to another practice/provider

Practice/Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Fees

There is a \$15 non-refundable retainer fee per complete record at time of request payable by cash or credit/debit card only (no checks).

Records are \$.50 per page, not to exceed \$50 per record. This includes Medicaid/Medicare patients.

Reason for records request

Leaving GLP: insurance change

New insurance: _____

Leaving GLP: change of primary care physician

Leaving GLP: dissatisfied

Please explain: _____

Copy of record for personal use

Other

Please specify: _____

Authorization

Parent/Guardian, or patient if 18 or older

I _____

authorize Greater Lowell Pediatrics, Inc. to release my/child's:

Complete medical record

Only the following specific information:

Release of sensitive information

I understand that if my medical records contain sensitive related information to drug and/or alcohol abuse, mental health visits, sexually transmitted disease, social service, infertility, abortion, child abuse, sexual abuse, assault, rape and sexual transmitted disease, Hepatitis, HIV/AIDS, I elect the following:

I agree to the release of the information

I do not agree to the release of this information

Signature of parent/guardian, or patient if 18 or older:

Date: _____

Please fax completed requests to

Lowell: 978-441-2550

Westford: 978-392-8500