Medical Record Release

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535
wmpeds.com

Patient information

Patient name: ______________________________

Date of birth: ______________________________

Phone: ______________________________

Address: ______________________________ Apt #: ________

City: ______________________________ State: ________

Zip: ______________________________

Release information to

Name/Facility: ______________________________

Address: ______________________________

City: ______________________________ State: ________

Zip: ______________________________

Specific information to be disclosed and released

○ Medical record from this date: ______________________________
to this date: ______________________________

○ Entire medical record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults.

Comments: ______________________________

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Specific information to be withheld

To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. I have indicated below that I do or do not permit information of this type, if it exists, to be released. I understand that if I do not indicate a choice, Westwood-Mansfield Pediatric Associates will release such information about me if it exists.

HIV/AIDS infection .... ○ Yes ○ No

Genetic information .... ○ Yes ○ No

Mental health .... ○ Yes ○ No

Sexually transmitted diseases .... ○ Yes ○ No

Treatment for alcohol and/or drug abuse .... ○ Yes ○ No

Specific information to understand

- I understand that my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.
- It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Westwood-Mansfield Pediatric Associates. I understand that any previously disclosed information would not be subject to my revocation request.

Reason for release

In an effort to better serve our patients, it is important for us to understand the reason that your child/young adult is leaving our practice. Please select the reason below and provide a description as well. You may utilize the back of this form if more space is needed.

❑ Transfer to an adult provider

❑ Moving away to:

City: ______________________________ State: ________

❑ Insurance change

❑ Providers not in new network

Network name: ______________________________

❑ Tiering/higher co-pay/higher deductible cost

❑ Long wait times

❑ Management of my child's health care

Please elaborate: ______________________________

❑ Unsatisfactory staff interaction

Please elaborate: ______________________________

❑ Other: ______________________________

This form must be fully complete before signing

Signature of patient or patient's legal representative:

____

Print patient's name:

____

Print legal representative's name (if applicable):

____

Relationship to patient: ______________________________

Date: ______________________________