



257 Station Avenue  
 South Yarmouth, MA 02664  
 Phone: (508) 500-6622  
 Fax: (508) 785-6120

**Authorization for Star and Fox Pediatrics to RECEIVE Medical Records**

Patient Name:	Date of Birth:
---------------	----------------

I, \_\_\_\_\_, hereby authorize the release of medical information **TO**

**Star and Fox Pediatrics, PLLC  
 257 Station Avenue  
 South Yarmouth, MA 02664  
 Phone: (508) 500-6622/Fax: (508) 785-6120**

**FROM:**

Doctor/Clinic/Hospital:		
Street Address:		
City:	State:	Zip:
Phone #:	Fax #:	

**Information to be released:**

- Complete medical record **including** protected health information (see below)

**Purpose of disclosure:**

- Treatment/continuing medical care

**Authorization to release protected information (required):**

I **DO NOT AUTHORIZE** the release of the following protected or privileged information that I have initialed below (only initial if you do NOT want to release this information):

- |  |  |
|--|--|
| <input type="checkbox"/> Mental health/psychotherapy notes/information | <input type="checkbox"/> Sexually transmitted disease (STD)    |
| <input type="checkbox"/> Social work counseling/therapy                | <input type="checkbox"/> Sexual abuse/rape                     |
| <input type="checkbox"/> HIV tests and related information             | <input type="checkbox"/> Domestic violence victims' counseling |
| <input type="checkbox"/> Alcohol/substance abuse                       | <input type="checkbox"/> Genetic testing                       |
| <input type="checkbox"/> Developmental disability                      |  |

I understand that I may revoke this authorization in writing at any time. This authorization shall remain in effect for 90 days unless specifically revoked in writing. The signature of the patient is to be obtained unless the patient is under 18 years old then the signature of the legal guardian is required.

Patient/Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_