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

Authorization for Star and Fox Pediatrics to SEND OUT Medical Records

Patient Name:	Date of Birth:

I, ____________________________, hereby authorize the release of medical information **FROM**

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

TO:

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):

◻ Mental health/psychotherapy notes/information
◻ Social work counseling/therapy
◻ HIV tests and related information
◻ Alcohol/substance abuse
◻ Developmental disability
◻ Sexually transmitted disease (STD)
◻ Sexual abuse/rape
◻ Domestic violence victims' counseling
◻ Genetic testing

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:_______________