Authorization to Receive Medical Records from Another Practice

Practice **Requesting** Records: Please mail or fax requested records here

Longwood Pediatrics, LLP
ATTN: Medical Records
319 Longwood Avenue
Boston, MA 02115

Telephone: 617-277-7320
Fax: 617-277-7834

*Please note that a patient may designate up to two (2) outside care providers to have permanent authorization to obtain copies of their medical records. This authorization may be revoked at any time upon your request. If you would like the above named care provider to have such access or update existing care providers, please choose one of the following:

- ☐ Please give the above named care provider authorization to my medical records
- ☐ Please replace _____ (existing authorization) with the above named care provider
- ☐ Please remove the above named care provider's authorization.

The purpose or need for disclosure:_____

Date Range of Information to be released: From: __/__/____ To: __/__/____

Please check specific information to be released:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Reports
- ☐ Outpatient Progress Notes
- ☐ Constitution Reports
- ☐ Pulmonary Function Tests
- ☐ Tissue Exam reports
- ☐ Nuclear Medicine Reports
- ☐ Nuclear Medicine CD Images (bone scan, etc.)
- ☐ Heart Diagnostics
- ☐ Radiology Reports
- ☐ Radiology CD Images (CT/x-ray, etc.)
- ☐ Lab Results
- ☐ Other (Please Specify):_____

Practice **Releasing** Medical Information:

Name (required):_____ Address:_____ _____ _____	Telephone: (____) ____-_____ **Fax (required): (____) ____-_____**

Patient Information:

Patient Name	Daytime Telephone	Date of Birth
	(_____)_____-_____	____/____/_____

AUTHORIZATION: Permission is hereby granted to the Longwood Pediatrics LLP to receive medical information from the individual/organization as identified above.

(Note: submission of this form authorizes the release of the information specified within one year from the date of signature.)

Patient/Authorized Signature	Print Name	Date
		___/___/_____