41 North Road, Suite 200 ○ Bedford, MA 01730
P: 781.275.KIDS (5437) ○ F: 781.275.6212

Medical Records Release

I do hereby authorize Bedford Pediatrics to ☐ **RELEASE** ☐ **RECEIVE** ***copies of my medical records.***

Patient Name: ______________________________ D.O.B: ______________

Address: ____

City: ______________________________ State: ________ Zip Code: ______________

Phone: ______________________________

Clinician or person to ☐ **RELEASE** ☐ **RECEIVE** ***copies of my medical records.***

Name of Person or Facility: ____

Address: ____

City: ______________________________ State: ________ Zip Code: ______________

Phone: ______________________________ Fax: ______________________________

Please select all of the specific documents that apply to your request:

- ☐ Entire Medical Record
- ☐ Clinical Notes
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Labs/Pathology Reports
- ☐ Operative Notes
- ☐ Emergency Room/Urgent Care Notes

Please place initials beside the options below to authorize the release of sensitive information pertaining to:

__________ Mental Health __________ Drugs and/or Alcohol

__________ Genetic Testing __________ HIV/STD Infectious Disease Testing

____ Date: ______________

Patient Signature if over 18 years old

____ Date: ______________

Parent/Guardian Signature if under 18 years old

☐ Mail to address above ☐ Pick up when ready ☐ URGENT! Fax to: ______________

(maximum 10 pages)