HEALTH CHILDREN'S CARE

Pediatrics
Carolyn Thumser, M.D.
Lars Lundgren, M.D.
Stacey Sheehan, M.D.
Eric Bucher, M.D.
Christine Riccardi, M.D.
Celeste Dunn, M.D.
Alta Tusini, M.D.
Emily Kinn, M.D.
Jennifer Pollard, PPCNP-BC
Mary Elizabeth Meehan, CPNP-PC
Jodi Cobb, CPNP-PC
Terry Reardon-Pollini, PPCNP-BC
Michael Keaney, CPNP-PC
Allison Niciu, CPNP-PC
Angelina Comei, CPNP-PC
Nicole DiLando, CPNP-PC

Newburyport
257 Low Street
Newburyport, MA 01950
Lower Level
p. 978-465-7121
f. 978-462-5304
Upper Level
p. 978-388-9880
f. 978-388-4897

Haverhill
600 Primrose Street
Suite 200
Haverhill, MA 01830
p. 978-373-6557
f. 978-374-5096

Authorization to Release and/or Receive Health Information

Patient Name_____ DOB_____
Phone _____ Address_____
City_____State_____ Zip _____

I AUTHORIZE:

Practice Name: _____
Address: _____
Phone: _____
Fax: _____

TO RELEASE INFORMATION TO:

Practice Name: _____
Address: _____
Phone: _____
Fax: _____

Purpose for This Request: (Check One)
□ Health Care □ Insurance Coverage □ Personal □Transferring Care

Type of Records Requested: (Check One)
□ Copy of entire medical record as allowed by the law
□ Records from (start date):_____ to (end date): _____
□ All medical records related to a specific illness or injury: _____
□ Specific information (Select Those That Are Applicable)
□ Procedure Report □History & Physical □Physical Therapy
□ Lab Results □X-Ray Reports □ Other: (Please Specify): _____

I understand the information in my health record may include information relating to sexually transmitted disease, behavioral or mental health services, and/or treatment for alcohol and drug abuse. **INITIAL HERE:** _____

This authorization expires 1 YEAR from the date signed.

I understand that
- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance to my prior authorizations.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be disclosed again.
- There is a ***$10 CHARGE PER CHILD*** for record requests to transfer, which can be picked up or mailed.

Signature of Patient or Representative _____**Date** _____

Relationship to Patient (if requestor is not patient) _____