Pediatrics

Carolyn Thumser, M.D.
Lars Lundgren, M.D.
Stacey Sheehan, M.D.
Thomas Carmichael, M.D.
Eric Bucher, M.D.
Christine Riccardi, M.D.
Kofoworola Onaleye, M.D.
Jennifer Pollard, C.P.N.P.
Mary Elizabeth Meehan, C.P.N.P.
Donna Gustafson, C.P.N.P.
Jodi Cobb, C.P.N.P.
Terry Reardon-Pollini, C.P.N.P.
Michael Keaney, C.P.N.P.
Allison Niciu, C.P.N.P.

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
Haverhill, MA 01830
p. 978-373-6557
f. 978-374-5096

Children's Health Care

Authorization to Release and/or Receive Health Information

Name | Date of Birth | Phone

Home Address | City | State | Zip

I authorize: to release information to:

PURPOSE FOR THIS REQUEST: (check one)
☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (check one)
☐ Copy of entire medical record as allowed by the law
☐ All medical records related to a specific illness or injury: _____
☐ Specific information (select those that are applicable)
☐ Procedure Report ☐ History & Physical ☐ Physical Therapy ☐ Lab Reports
☐ X-ray Reports ☐ Other: (please describe) _____

SENSITIVE INFORMATION: Please read carefully: By law if you want us to release any of the following information from your record, you must sign below: Place your initials next to "Yes" or "No"

Drug/Alcohol Information	Yes _____ No _____
Mental Health Including ADHD	Yes _____ No _____
AIDS/HIV Testing and Results	Yes _____ No _____
Sexually Transmitted Diseases, Testing & Results	Yes _____ No _____
Cummunicate Diseases	Yes _____ No _____

And is limited to the time period from _____ to _____

This authorization expires on _____ or 60 days 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 authorization;
- 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 at the office or mailed.

Signature of Patient or Representative | Date

Relationship to Patient (if requestor is not patient