Pediatrics
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.
Molly Snyder, M.D.
Matthew Dashkoff, 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
Emma Foley, 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

For Office Use Only:

Date Completed: _____

$6.50 Fee Paid: Check Cash Card

Method:
Faxed Mailed Paper Mailed USB
Patient/Parent Pick Up

Staff Initials: _____

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)
□ Entire Medical Record
□ 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:

- **There is a $6.50 processing fee for transferring medical records.**
- 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.

_____
Signature of Patient or Representative

_____
Relationship to Patient (if requestor is not patient)

Date _____