NORTHERN BERKSHIRE PEDIATRICS, LLP
AMBULATORY CARE CENTER, 77 HOSPITAL AVE., SUITE 302
NORTH ADAMS, MA 01247
PHONE: (413) 663-8365 FAX: (413) 662-2363

REQUEST FOR MEDICAL RECORDS

PATIENT INFORMATION:
Patient's name _____
Date of Birth _____
Address _____
_____ Phone _____

PREVIOUS PHYSICIAN/PHYSICIAN AUTHORIZED TO RELEASE RECORDS:
Physician _____
Address _____
_____
Phone _____ Fax _____

RELEASE THE FOLLOWING INFORMATION:
____ Copy of all medical records (including records from prior providers and specialists)
____ Copy of all medical records from previous practice ONLY
____ Immunization records
____ All diagnostic testing
____ Other (please specify) _____

____ I further authorize the disclosure of SENSITIVE and/or MEDICAL DATA including HIV, alcohol, psychiatric, and drug information, sexual assault or abuse, child abuse or neglect, sexually transmitted diseases, sexual preference, family interaction issues, regardless of source.

PLEASE RELEASE COPY OF RECORDS TO:
Northern Berkshire Pediatrics
77 Hospital Avenue Suite 302
North Adams, MA 01247

*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect ability to obtain treatment.
*I understand that the facility, its employees, and the physicians are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated in the authorized herein.
*I understand that I may revoke this authorization at any time by giving written notice to your office. This authorization expires at age 18 if signed by legal representative. (unless noted otherwise)

_____ _____
Signature of patient age 18 or older DATE
Signature of parent (if minor) or legal representative