SELF-HISTORY FORM

Authorization for Release of Medical Information

Bridgewater Pediatrics
Boston Children's
Primary Care Alliance

bridgewaterpediatrics.com
508-697-8116

Please complete this form thoroughly. Your medical record cannot be released until this form is completed, signed by the patient or legal guardian and returned to our office. There may be a processing fee associated with this request.

Patient information

Patient first name: _____

Patient last name: _____

Date of birth: _____

Phone: _____

Address: _____ Apt #: _____

City: _____ State: _____

Zip: _____

Who has your records now?

Physician: _____

Address: _____

City: _____ State: _____

Zip: _____

To whom do you wish to release your records?

Physician: _____

Address: _____

City: _____ State: _____

Zip: _____

Which records would you like released?

❍ All records, **or**

❍ Dates of service from: _____ to: _____

You must specifically check yes or no for each category below:

Abortion ..... ❍ Yes ❍ No

AIDS ..... ❍ Yes ❍ No

HIV Testing ..... ❍ Yes ❍ No

Alcohol Abuse ..... ❍ Yes ❍ No

Substance Abuse ..... ❍ Yes ❍ No

Illegitimate Birth ..... ❍ Yes ❍ No

Infertility Studies ..... ❍ Yes ❍ No

Mental Health Visits ..... ❍ Yes ❍ No

Anxiety/Depression ..... ❍ Yes ❍ No

Eating Disorders ..... ❍ Yes ❍ No

Sexual Assault/Rape ..... ❍ Yes ❍ No

Sexually Transmitted Disease .... ❍ Yes ❍ No

Signature

I hereby authorize the release of the above information to the address indicated.

Patient signature:

_____

Date: _____

Parent/Guardian signature:

_____

Date: _____

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

Please allow 10 business days for your records to be released.