West Cambridge Pediatric & Adolescent Medicine

Daniel Epstein, M.D., FAAP
Johyne Ballenger, M.D., FAAP
Pearl Riney, M.D., FAAP
Jennifer Gill, M.D., MPH, FAAP
Sarah Teasdale, M.D., EdM, FAAP

Jonathan Gall, M.D., Ph.D.
Cindy Luthern, CPNP, M.S., RN
Greta Feinberg, CPNP, M.S., RN
Aislyn Cangialose, CPNP, M.S., RN

Authorization For Release Of Medical Records

Patient name: _____
DOB: _____
Patient address: _____

I am requesting records for the following reason: (please check one)

_____ Leaving the practice
_____ Receiving lab results
_____ Requested by a specialist
_____ Other_____

I authorize West Cambridge Pediatric & Adolescent Medicine to release a complete copy of my or my child's medical record or if applicable and approved by the patient, a summary of the medical records to:

Name: _____
Dept/Attn: _____
Address: _____
_____
_____

Please indicate if you would like any information in the categories listed below to be withheld:

Mental health _____
Drug treatment _____
Alcohol treatment _____
Adoption _____
Sexually transmitted disease _____
Termination of pregnancy _____

I understand and agree that I am financially responsible for the following fees associated with my request: Copying charges, including cost of supplies, labor and postage related to the production of my information. I understand that the fee for this service is $15.00.

Signature: _____Date_____
Patient, Parent or Legal Guardian
Print Name: _____