West Cambridge Pediatric and Adolescent Medicine
575 Mount Auburn Street
Cambridge, Massachusetts 02138-4627
Telephone: 617-547-1995
Facsimile: 617-492-1118

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 _____ Requested by a specialist

_____ Receiving lab results _____ 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 _____ Termination of Pregnancy _____
Drug Treatment _____ Sexually Transmitted Disease _____
Alcohol Treatment _____ Adoption _____

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

Signature: _____
Patient, Parent or Legal Guardian

Print Name: _____ **Date:** _____

Johnye Ballenger	Daniel Epstein	Pearl Riney	Jennifer Gill
617-547-2093	617-354-6660	617-547-1995	617-547-1995