Daniel Epstein, M.D., FAAP
Johnye 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 To Release Information

I, _____, am no longer a minor and authorize West Cambridge Pediatrics & Adolescent Medicine to share medical information and results with my parent(s)/guardian.

As per Massachusetts and/or Federal Law, certain types of medical information are protected by law from release without specific consent, and will not be released as a result of this authorization.
If you **DO NOT** want these records released, please check the appropriate line(s) below:

_____HIV results
_____Mental Health records and references
_____Substance abuse (alcohol, narcotics, prescription drugs)
_____Communication with office psychologist
_____Sexually transmitted diseases
_____Termination of pregnancy
or
_____Please release all medical information and results to my parent(s) or guardian.

My date of birth:_____
My cell phone #:_____

I will notify West Cambridge Pediatric & Adolescent Medicine, in writing, when this document is no longer valid.

Parent(s)/Guardian name:_____

Signature of patient:_____ Date:_____