Blackstone Valley Pediatrics

2 Meehan Lane, Cumberland, RI 02864
P: 401.658.2525 F: 401.658.3031

501 Great Rd suite 201, North Smithfield, RI 02896
P: 401.769.7075 F: 401.769.7840

Release of Medical Records

Patient Name:_____ **DOB:** _____

Address:_____

Phone Number: _____

By signing this permission form, I allow Blackstone Valley Pediatrics to **send/obtain** a copy of my Medical Records **to/from**:

Name:_____

Address:_____

Phone/Fax Number:_____

Medical Records to be sent: (check one)

- All medical Records
- Only the following Medical Records:_____

Reason why I am giving permission to send medical records:

- New PCP
- Lawyer
- Insurance
- Personal
- Other:_____

I understand that:

- This permission form is only good for one year from the date signed
- I may cancel my permission at any time. I need to write you a letter to cancel permission. I need to bring in or mail this letter to Blackstone Valley Pediatrics at 2 Meehan Lane Cumberland RI 02864. I understand that Blackstone Valley Pediatrics may send my records before I cancel this permission. There is nothing that can be done about that.
- I do not need to sign this permission form to get medical treatment.
- I do not need to sign this permission form at all.
- I am allowed to get a copy of this permission form.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I am allowed to look at my records or get a copy of my records before they are sent. The person who receives my records may not be required to protect my information and may share my information with others without my permission
- I will be charged a copying fee of $5 per copy needed. Records being mailed will be subject to an additional fee.
- This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

Patient/Parent Name:_____

Patient/Parent Signature:_____Date:_____

Special Medical Records (Check all that apply):

Some medical records have special protections. We need your specific permission to send the medical records listed below. Sign below to send these special medical records. Please check the box next to the special medical records you give us permission to send.

- Drug and Alcohol use records
- Mental health records
- HIV/AIDS Records
- Sexual abuse/assault and domestic violence records
- Sexually-transmitted infection records

Patient/Parent Name: _____

Patient/ParentSignature:_____Date:_____

Records Pick Up

I Authorize:_____to pick up my medical records

Relationship:_____