Pediatrics at Newton Wellesley, P.C.

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AUTHORIZATION FOR RELEASE OF INFORMATION VIA CARE EVERYWHERE

The completion of this form authorizes the providers at Pediatrics at Newton Wellesley to communicate with the professionals listed below regarding my child, _____.
PATIENT NAME AND DATE OF BIRTH

Name: _____ Role: _____

Location/Facility: _____ Phone #: _____

Name: _____ Role: _____

Location/Facility: _____ Phone #: _____

Name: _____ Role: _____

Location/Facility: _____ Phone #: _____

Name: _____ Role: _____

Location/Facility: _____ Phone #: _____

○ *I give my permission for my/the patient's medical record from Pediatrics at Newton Wellesley to be shared with the person/organizations listed above. My/the patient's medical record may include patient history, office notes (except psychotherapy notes), test results, radiology studies, films, referrals and consults.*

○ *I DO NOT give my permission for my/the patient's medical record from Pediatrics at Newton Wellesley to be shared with the persion/organization list above.*

Parent/Guardian Signature _____ Date _____

Parent/Guardian Printed Name _____