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pediatric
PHYSICIANS

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Authorization To Release Information

I, _____, am no longer a minor but authorize Weston Pediatric Physicians, P.C. to share medical information and results with my parents/guardian.

As per Massachusetts and/or Federal Law certain types of medical information is 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 box below:

☐ AIDS/HIV testing and results
☐ Mental Health records and references
☐ Substance abuse (alcohol, narcotics, prescription drugs)
☐ Communications with social workers
☐ Sexually transmitted diseases
☐ Domestic abuse records

or

☐ Please release all medical information and results to my parents/guardian.

My date of birth is _____
My cell number is _____

I will notify Weston Pediatrics, in writing, when this document is no longer valid.

Parents/Guardian Name _____
Signature of patient _____ Date _____