Medical Record Release

I do hereby consent and authorize Arlington Pediatrics Associates to release and receive copies of my medical records.

Patient Name: _____ D.O. B: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Records requested to/from:
Name of Person or Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Purpose of Request: _____

Please select all of the specific documents that apply to your request:

- ☐ Entire Medical Record
- ☐ Clinical Notes
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Labs/Pathology Reports
- ☐ Operative Notes
- ☐ Emergency Room/Urgent Care Notes

Please place initials beside the options below to authorize the release of sensitive information pertaining to:

_____ Mental Health _____ Drugs and/or Alcohol

_____ Genetic Testing _____ HIV/STD Infectious Disease Testing

_____ Date: _____
Patient Signature if >18

_____ Date: _____
Parent/Guardian if patient <18

Mail to address above:_____ Pick-up when ready_____ **URGENT: Fax to:**_____
Maximum 10 Pages

5 Water Street, Arlington MA 02476 **ph: 781-641-5800** **fax: 339-707-6028**