



**AUTHORIZATION FOR RELEASE OF  
MEDICAL RECORD INFORMATION**

Patient Name	Date of Birth	Telephone #	
Street Address	City	State	Zip

I hereby authorize the disclosure of information in my/my minor child's medical records

- to  from: Child and Adolescent Health Specialists, PC  
(check one) 223 Chief Justice Cushing Hwy, Suite 201  
Cohasset, MA 02025
- Robert F. Belknap, MD, MPH - Developmental-Behavioral Pediatrics
  - Jocelyn R. Healey, MD - General Pediatrics
  - Arlene Dijamco, MD - General and Integrative Pediatrics

- to  from: Name: \_\_\_\_\_  
(check one) Relationship to patient:  Parent  Physician  Other \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone #: \_\_\_\_\_

I authorize Child and Adolescent Health Specialists, PC to review or release a copy of my/my minor child's medical records including any sensitive medical information unless otherwise excluded below.\*

I understand that Child and Adolescent Health Specialists, PC will not condition my treatment on whether I provide authorization for the requested use or disclosure unless the treatment is necessary for the purpose of creating protected health information for disclosure to a third party (e.g. physical exams for school, camp, employment, etc.).

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

I understand that I may revoke this consent at any time by notifying Child and Adolescent Health Specialists, PC in writing. However, such revocation does not affect any actions taken by Child and Adolescent Health Specialists, PC before receiving my written notification. This request may take up to 30 days to process.

**There is a \$15.00 processing fee per child for records to be sent from this office. Payment must accompany this form. Unpaid balances must be addressed.**

Medical record information will not be released or reviewed without a valid signature below. This authorization will expire one year from the signature date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Legal guardian if a minor child)

\* I request that Child and Adolescent Health Specialists, PC release a copy of my/my minor child's medical records with the **EXCLUSION** of any reference to: (circle all that apply) drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment, or other protected information:  
(please specify) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Legal guardian if a minor child)