West Cambridge Pediatric and Adolescent Medicine
575 Mount Auburn Street
Cambridge, MA 02138-4627
Phone: 617-547-1995 Fax: 617-492-1118

Authorization for the Release of Protected Health Information

Patient Name _____ Birth Date _____

Address _____ Phone _____ _____

I hereby authorize West Cambridge Pediatrics to:

❑ Release health information to:
(If you are transferring **from** WCPAM **to** another provider)
❑ Receive health information from:
(If you are **new to** WCPAM needing records **from** your previous provider)

Practice/Physician _____
Address _____
Phone number _____ Fax number _____

Reason for requesting this information:

❑ Transfer to adult/family practice
❑ Transfer due to a change in insurance
❑ Transfer, moved out of the area
❑ Other, please specify _____

This medical information includes the following types we have in our possession. We will release all records created at the practice.
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 because of this authorization. If you **DO NOT** want these records released, please check the appropriate box(es) below:

❑ AIDS/HIV testing and results
❑ Mental health records and references, including communication with a mental health provider
❑ Substance abuse
❑ Sexually transmitted diseases
❑ Termination of pregnancy
❑ Adoption

Patient signature, if 18 years or older OR parent or guardian signature for patients under 18

X _____

Date: _____ **Relationship to patient:** _____