

PARTNERS IN PEDIATRICS

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient: _____ Address: _____

Date of Birth: _____

SSN: _____ Telephone: _____

Release Records To: _____ Obtain Records From: _____

The Purpose for this Release of Information is:

Personal Use Transfer of Care Insurance School Legal Other: _____

Information to be Released:

Entire Record or Dates of Service: _____

or Specifically: Problem List Immunizations Record Last History and Physical
 Medication List Other Consultation Reports

(This Authorization includes allowing the transfer of information regarding: AIDS, HIV, psychiatric disorders, and history of treatment for drug or alcohol abuse.)

Do you authorize the release of these records as well? Yes No

I understand that this authorization may be revoked at any time, in writing, and this authorization will expire in 90 days from the date below.

Signed: _____ Printed Name: _____ Date: _____
Patient/Legal Guardian

Relationship: _____

*This authorization does not allow an agency receiving records from further distributing them without additional written consent of the patient.

*A record request from must be signed by a parent, legal guardian, or the patient (if over 18). Allow 2 or more weeks for processing. There is a \$15 fee, due at the time of request, and may be paid via cash, debit, or credit card in person or over the phone.