Garden City Pediatric Associates, LLC
83 Herrick Street, Suite 1003
Beverly, Massachusetts 01915
Tel. (978) 927-4980 Fax (978) 922-9115

AUTHORIZATION TO RELEASE MEDICAL BILLING/ PERSONAL MEDICAL INFORMATION

DATE: _____

I _____

[ ] Do

[ ] Do Not

Give permission to:

Dr _____and/or Garden City Pediatrics office

staff to speak to _____

relationship: _____ regarding my:

[ ] Medical billing info
[ ] Personal medical information

I am authorizing the release of the following information (check all that apply)

[ ] all records

[ ] all records except sensitive information (drugs and/or alcohol abuse, psychiatric care, sexually transmitted diseases, other sensitive information)

[ ] HIV (AIDS) testing/treatment records

[ ] Other _____

This authorization is voluntary and may be revoked at any time by informing us in writing. I understand this authorization will expire:

[ ] indefinitely [ ] other _____

_____ _____
Patient name DOB

_____ _____
Patient Signature Date