BENJAMIN SPINGARN ROTTENBERG
LLC, PEDIATRIC & ADOLESCENT MEDICINE

Release of Medical Records Form

Patient:	
Name:	Date of Birth: / /
Address:	

From:	**Release To:**	**Communicate With:**
Drs. Benjamin, Spingarn, & Rottenberg	Name:	
	Organization:	
1400 Centre Street, Suite 203	Address:	
Newton, MA 02459		
Phone: 617-244-9929	Phone:	
Fax: 617-244-9935	Fax:	

I, (or I on behalf of) _____

(neatly print patient's name)

give permission to individuals or organizations listed above to release and/or exchange information about my medical history. This includes my diagnosis and/or treatment related to alcohol abuse, substance abuse, mental health or psychiatric care, and any lab results including HIV testing.

The purpose of this release of information is to allow the individuals or organizations to assure continuity of care among my health care providers, including carrying out discharge planning arrangements, to carry out utilization review and quality assurance activities, and to determine clinical eligibility for covered benefits, and to make payment decisions.

If there are any limitations about the release of information, they are written here:

I may cancel this agreement at any time except if the information has already been released.

Dates to release: Entire Record: ☐
Specific Dates: _____/_____/_____to _____/_____/_____

I understand that there is a standard fee of $25.00 to copy records.

Patients aged 18 years and over are considered adults and must sign for themselves.

Signature: _____ Date: _____/_____/_____