Release of Medical Information

Brookline Pediatrics
1180 Beacon St. Suite 7A
Brookline, MA 02446
Phone: (617) 232-2915
Fax: (617) 232-2337

Name of patient: _____

Date of birth: _____

I, _____ give permission for my/ my child's protected health information to be released to the office of:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

I give permission for Brookline Pediatrics to share protected health information with the above provider/practice as well. I understand that the information may be transmitted by secure fax, secure electronic means, or by conversation between the provider/practice.

Signature: _____ Date: _____

Print name: _____

Relationship to patient: _____

Please be aware there is a **$25** fee for medical release.