Authorization to Transfer Medical Records

Weymouth Pediatrics
851 Main Street; Suite 25
Weymouth MA 02190

I hereby authorize, _____ M.D., to

Provide medical information of

Patient's name: _____Date of birth_____

to Dr. _____

Located _____Suite_____

City State Zip

Ph: _____ _____fax: _____

Any and all information may be released, including, but not limited to, immunization and mental health records.

I understand and agree to pay a reasonable charge to cover the cost of transfer. I understand the costs will be computed based on a copying fee of 25 cents per page for standard documents, and reasonable clerical and postage costs for mailing the records.

I understand that I may receive a copy of this authorization upon request.

Signed:_____ Date: _____

Print name: _____

Relationship to patient: _____

July 2020