



Healthcare South, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete thoroughly. Your medical records cannot be released until this form is completely signed by the patient or legal guardian and returned. There may be a processing fee associated with this request.

PLEASE PRINT!!!

Practice Locations:

Pediatrics

Felisa Y. Sly, MD
825 Main Street
So. Weymouth, MA 02190
Tel: (781) 331-9114

Bartley G. Cilento, MD
7 Driftway
Scituate, MA 02066
Tel: (781) 545-3391

Robert W. Walker, MD
435 Furnace Street
Marshfield, MA 02050
Tel: (781) 837-1108

South Shore Pediatric Associates

Francis J. Kilduff, MD
Gerald B. Katz, MD
Joyce M. Traina, MD
Patricia I. Tai, MD
70 Pleasant Street
So. Weymouth, MA 02190
Tel: (781) 337-5680

Scituate Pediatrics

David P. Morin, MD
Donna A. Zambuto, MD
Julian C. Huang, MD
Jeanette S. Parris, MD
Alexander Marcus, MD
10 New Driftway, Suite 201
Scituate, MA 02066
Tel: (781) 545-9225

Hanover Pediatrics

Jon R. Jolles, MD
Thomas C. Johnston, MD
Kelli A. Kennedy, MD
51 Mill Street
Building E, Suite 17
Hanover, MA 02339
Tel: (781) 826-2131

Cohasset Pediatrics

Kevin J. Corbett, MD
Sarah M. Axel, MD
Margaret G. Carolan, MD
J. Douglas Pinney, MD
223 CJC Highway, Suite 101
Cohasset, MA 02025
Tel: (781) 383-6800

Family Medicine

Cohasset Family Practice

Alisa A. Freed, MD
Steven T. Golden, MD
Alexis M. Klock, MD
Brian H. McPhillips, MD
Cheryl M. Mitchell, MD
James L. Mitterando, MD
223 CJC Highway, Suite 301
Cohasset, MA 02025
Tel: (781) 383-6261

Stephen K. Lane, MD
56 New Driftway, Suite 301
Scituate, MA 02066
Tel: (781) 544-1388

John P. Mulkern, MD
700 Congress Street, Suite 302
Quincy, MA 02169
Tel: (617) 770-4411

Patient Name: _____ Date of Birth ____/____/____
Last First MI

Address: _____
Street City State Zip

Telephone: _____ Fax: _____

I hereby authorize _____ M.D./D.M.D. to release my records.

Physician's Address: _____
Street City State Zip

Telephone: _____ Fax: _____

Please release the following information for the purpose of (i.e. - transfer of care, special consultation, etc.)

_____ All Records or Dates of Treatment

Send _____
 To _____

Signature Required

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date. Additional authorization for redisclosure beyond recipient is required.

 Patient's Signature Date

 Witness Signature Parent/Guardian's Signature (If Patient is a minor)

Release For Sensitive Information – Signature Required

I UNDERSTAND THAT IF MY MEDICAL RECORD CONTAINS INFORMATION IN REFERENCE TO DRUG AND/OR ALCOHOL ABUSE, PSYCHIATRIC, VENEREAL DISEASE, SOCIAL SERVICE, HEPATITIS B TESTING/TREATMENT, AND/OR SENSITIVE INFORMATION, I AGREE TO ITS RELEASE.

 Signature of Patient or Legal Guardian Date

Release of HIV Information – Signature Required

IN ADDITION TO THE ABOVE SIGNATURES, IF YOU WANT YOUR HIV (AIDS) TESTING/TREATMENT RECORDS RELEASED YOU MUST SIGN AND DATE ON THE LINE BELOW.

I AGREE TO THE RELEASE OF THIS INFORMATION.

 Signature of Patient or Legal Guardian Date