Nicholas Kasdon MD
Haesik Min MD
Tess Alejo MD
Ying Yi Zhang MD

**READING PEDIATRIC ASSOCIATES PC**
52 Haven Street
Reading, MA 01867
Phone: 781-944-2050
Fax: 781-944-0232

Darcey Santos NP
Kathryn Graf NP
Mary Sforza NP

**GUARANTOR/PATIENT'S NAME:**_____

**ADDRESS:** _____

**PHONE NUMBER:** _____

**I AUTHORIZE:** (Name of Practice Releasing the Records)

_____

**TO RELEASE RECORDS OF:**

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

☐ Request Full Record **OR** ☐ Request Records for treatment dates _____ to _____

**OFFICE PHONE:**_____ **OFFICE FAX:**_____
(Phone Numbers of Practice Releasing Records)

**I authorize for the practice releasing these records to disclose the protected health information described below**:

☐ I authorize the release of my **complete** health record (if applicable this could include records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR**

I authorize the release of my complete health record **with the exception** of the following information:

☐ Mental Health Records
☐ Alcohol/Drug Abuse treatment
☐ Other (please specify):
☐ Communicable diseases (including HIV and AIDS)
☐ Pregnancy/ Sexual Activity

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**PLEASE MAIL THESE RECORDS TO:**
Reading Pediatric Associates PC
52 Haven Street
Reading, MA 01867
Tel: (781) 944-2050 Fax: (781) 944-0232

_____ _____

**GUARANTOR/PATIENT'S SIGNATURE** **DATE**