Authorization for the Release of Medical Records

Post Road Pediatrics
Boston Children's
Primary Care Alliance

postroadpediatrics.com
978-443-6005 | *fax* 978-443-8429

Patient last name:_____

First name: _____ MI: _____

Patient date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for Post Road Pediatrics to share my/the patient's medical record with the person or organization listed below. My/the patient's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

Choose one:

❍ Medical Record (except confidential information defined by Massachusetts law)
❍ Medical Record for the time from: _____ to: _____
❍ Only information from a certain illness or injury.

Please describe: _____

Send a copy of my/the patient's medical records to:

Name: _____

Organization _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (se ually transmitted) or other communicable disease(s)
- Results of tests for HIV/AIDS

Please initial all parts you agree to have shared.

By putting my initials by each item below I give permission for Post Road Pediatrics to share this type of information. I understand that if I do not initial the box, Post Road Pediatrics will not share this information about me/the patient's health to the person or organization listed above.

HIV test results
(Specific patient authorization required for each release request)

Specify dates: _____
Initial if info **may be shared**: _____

Genetic screening test results (Specify type of test):

_____
Initial if info **may be shared**: _____

Alcohol and Drug Abuse Treatment Records
Protected by Federal Confidentiality Rules 42 CFR Part 2. Federal rules prohibit any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.
Initial if info **may be shared**: _____

Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC). I understand that my permission may not be required to release my mental health records for payment purposes.
Initial if info **may be shared**: _____

Confidential Communications with a Licensed Social Worker
Initial if info **may be shared**: _____

Information related to the use of alcohol, drugs, and/or tobacco
Initial if info **may be shared**: _____

Information related to a sexually transmitted disease, sexual activity and/or orientation
Initial if info **may be shared**: _____

Information related to diagnosis or treatment of pregnancy
Initial if info **may be shared**: _____

Information related to child abuse or neglect
Initial if info **may be shared**: _____

Information concerning family violence and/or Domestic Violence Victims' Counseling
Initial if info **may be shared**: _____

Other(s): Please list: _____
Initial if info **may be shared**: _____

NEXT PAGE >

I know I can revoke this form at any time. This means I can tell Post Road Pediatrics to stop sharing my/the patient's information. I know I cannot withdraw information that Post Road Pediatrics had shared before I told Post Road Pediatrics to stop. Post Road Pediatrics may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to Post Road Pediatrics telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Post Road Pediatrics telling them to revoke this form.

By signing below I agree that I understand the above and voluntarily allow my/the patient's medical record to be shared.

Patient's name: _____

Parent/Legal guardian's name (if applicable):

_____

Signature of parent/legal guardian/self (if 13+):

_____

Relationship to patient: _____

Date: _____

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Reason for release (optional):

In an effort to better serve our patients, it is important for us to understand the reason that you/the patient is asking for your medical record or leaving our practice. Please choose the reason below.

- ☐ Sharing with outside provider for treatment purposes
- ☐ Transfer to an adult provider
- ☐ Moving away to City: _____ State: _____
- ☐ Insurance change
- ☐ Provider(s) not in new network (network name)
- ☐ Tiering / higher co-pay / higher deductible cost
- ☐ Other, please describe: _____

Important Notice

You do not have to give permission to share these records. Post Road Pediatrics will not base your/the patient's treatment on whether or not you sign this form.

After your/the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to get a copy of this signed form.

First copy of record provided at no charge. A $25 fee applies for additional copies.