AUTHORIZATION FOR DISCLOSURE

Clinical Information for Patients 18 years or older

Post Road Pediatrics
Boston Children's
Primary Care Alliance

postroadpediatrics.com
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When you turn 18, Post Road Pediatrics requires that you make a decision about who we can communicate with regarding your medical care. If you choose to allow your parent(s) to be involved in your healthcare, please write their names in section A on the authorization form. Even if you include your parents on this form, certain information is still protected by Massachusetts law, including but not limited to HIV/AIDS testing and treatment, mental health diagnosis and treatment, and drug or alcohol use (unless you are a danger to yourself or others). You may give specific consent for these sensitive items to be disclosed on the authorization form.

If you decide that you will not allow Post Road Pediatrics to communicate with your parent(s) about your healthcare, indicate this by initialing section B on the authorization form. This means that no one but you will be allowed to call us and schedule or cancel appointments, request prescription refills or referrals, or pay any of your medical bills that are not covered by insurance. All interactions must be directly with you. Please make sure we have your phone number and address up to date in our system.

You are able to revoke/change your authorization at any time by putting your request in writing. If you have any questions about this form and what it means, please ask us!

Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Authorization section A

I authorize Post Road Pediatrics to communicate with the following person(s)

Person 1: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Person 2: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Person 3: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

**COMPLETE SECTION B,
NEXT PAGE >**

Authorization section B

I do not authorize communication between Post Road Pediatrics and my parents or former legal guardians.

I understand that I am responsible for all communication with Post Road Pediatrics including but not limited to the scheduling/canceling of my appointments, prescription refills and referral requests, and **paying any bills not covered by insurance**.

Initial if you are **declining** communication: _____

Post Road Pediatrics has my permission to release information acquired in the course of evaluation and/or treatment of the above named patient, including telephone contact and secure email. I understand the information may include the items initialed below (if applicable).

Please initial all elements you **agree** to have released:

Information related to a sexually transmitted disease, sexual activity and/or orientation

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

Information related to diagnosis or treatment of pregnancy

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

Information related to contraception and birth control prescriptions

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

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

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

Information related to the use of alcohol, drugs, and/or tobacco

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

Confidential Communications with a Licensed Social Worker

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

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. I can, however, cancel this authorization in writing at any time, except to the extent that Post Road Pediatrics has relied upon it.

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

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 released**: _____

Genetic Screening Test Results (Specify type of test)

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

Information related to child abuse or neglect

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

Information concerning family violence and/or Domestic Violence Victims' Counseling

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

In addition, I give permission to the medical and behavioral health providers of **Post Road Pediatrics** to share information with any emergency caregivers who are involved in my care in the event of a medical or psychiatric emergency.

This authorization is voluntary and I have the right to refuse to sign it. Signing this form is not a condition of treatment.

I may take back this authorization at any time by giving written notice of revocation; however such revocation would not affect any action taken by **Post Road Pediatrics** in compliance with this authorization before receipt of my written, hard-copy, revocation.

You may accept photocopies or facsimiles of this authorization.

This authorization will expire in 12 months from the date of signing, unless otherwise changed or revoked.

Signature of patient: _____

Date: _____

You have the right to have a copy of this form after you sign it. The original of this form will become part of the clinical record.

Verbal Consent

Obtained: ❍ via phone ❍ in person

From parent /guardian /patient (if 13+):

_____

on (date): _____ at (time): _____

Witness #1

Name: _____

Title: _____

Signature: _____

Witness #2

Name: _____

Title: _____

Signature: _____