AUTHORIZATION FOR DISCLOSURE

Clinical Information to Outside Provider

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: _____

I authorize Post Road Pediatrics to communicate with the following providers, as needed, to help with evaluation, treatment planning, and coordination of care:

Agency/Organization: _____

Name: _____Degree: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

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 review and initial all elements you **agree** to have 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**: _____

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**: _____

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

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

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

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**: _____

Genetic screening test results (Specify type of test):

_____

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

Information related to diagnosis or treatment of pregnancy

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**: _____

Other(s) Please list: _____

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 the care of my child 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 Parent/Guardian/Self (if 13+):

_____ Date: _____

Staff signature: _____

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: _____