Authorization for the Release of Psychotherapy Notes

Post Road Pediatrics
Boston Children's
Primary Care Alliance

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Important Notice: Any release of psychotherapy notes MUST be approved by the Behavioral Health Provider. The Provider can choose to deny any request.

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 psychotherapy notes with the person or organization listed below.

Choose one:

❍ All psychotherapy notes

❍ Psychotherapy notes for the period from: _____ to: _____

Share a copy of my/ the patient's psychotherapy notes with:

Name: _____

Organization _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

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. I am voluntarily allowing 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.

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