Medical Records Release Authorization

Wareham Pediatrics
Boston Children's
Primary Care Alliance

warehampeds.com
508-295-8622

Patient last name: ____

First name: ________________________________ MI: _________

Date of birth: ____

Phone: ____

Address: ____

City: ____________________________________ State:_________

Zip:_________________________________

Authorization

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

I give my permission for:

____

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:

❍ Complete 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:
____
____
____

❍ Specific Information:
____
____

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

Name: ____

Organization: ____

Address: ____

City: ____________________________________ State:_________

Zip:_________________________________

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 (sexually 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 Wareham Pediatrics to share this type of information. I understand that if I do not initial the box, Wareham Pediatrics will NOT share this information about me/the patient's health to the person or organization listed above.

HIV Test Results (Specific approval required for each release request)

Specify dates: ____

Initial: _________

Genetic Screening Test Results

(Specify type of test: ____________________________________

Initial: _________

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: _________

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: _________

Confidential Communications with a Licensed Social Worker

Initial: _________

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

Initial: _________

NEXT PAGE >

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

Initial: _________

Information related to diagnosis or treatment of pregnancy

Initial: _________

Information related to child abuse or neglect

Initial: _________

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

Initial: _________

Other(s): Please list: ____________________________________

____

____

Initial: _________

I know I can revoke this form at any time. I know I cannot withdraw information that Wareham Pediatrics had shared before I told Wareham Pediatrics to stop. If I no longer want my/the patient's medical record shared I will send a written letter to Wareham Pediatrics telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Wareham 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):

____

Relationship to patient:

____

Signature of Parent /Legal Guardian /Self (if 13+):

____

Date: ____

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

Reason for release

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. Wareham 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.