PEDIATRIC ASSOCIATES OF BROCKTON
(508) 584-1234

**A**uthorization for **R**elease of **P**rotected **H**ealth **I**nformation

Please Print

I hereby authorize:

_____
Physician/Medical Group

_____
Street

_____
City State Zip

To release to:

_____
Physician/Medical Group

_____
Street

_____
City State Zip

Name of Patient: _____ Date of Birth: _____

_____ _____

_____ _____

Address of Patient: _____
Street City State Zip

Home Phone #_____ Cell Phone #_____

I authorize the person(s) or organization indicated above, to release health information, including copies of my medical record of care, to the following person(s) or classes of persons (e.g. doctors, lawyers) at the locations/facilities listed above and for the purpose(s) described below:

**Purpose: (check the appropriate box)**

□ □ At request of patient □ □ Legal Matter □ Insurance

□ □ Medical Care □ □ Personal □ Other (please specify:)

_____

**Please note that there may be a fee associated with this request for copying your records for certain purposes.**

**DESCRIPTION OF INFORMATION TO BE RELEASED (Please check all that apply *and specify dates*):**

□ Last Physical Exam_____ □ Growth Charts_____

□ Immunizations_____ □ Lab Reports_____

□ X-ray Reports_____ □ Consultation Reports_____

□ Gyn Reports_____ □ All Medical Records_____

□ Other (please specify)_____

**Release of Sensitive Protected Health Information**

**I request and authorize the release of the specific categories of information that I have *INITIALED* below:**

____HIV test results (Patient Authorization required for each release request.) **Specify Dates:_____**

____HIV/AIDS medical treatment information

____STD (Sexually Transmitted Disease) medical treatment information (Other than HIV/AIDS)

____Genetic test results (excludes therapeutic genetic tests) (**Specify type of test)**_____

____Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted or written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2).

____ Other(s): Please Specify_____

**Confidential Details of:**

____Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)

____Social Work Counseling/Therapy

____Domestic Abuse/Violence Victims' Counseling

I understand that:

- I may revoke my authorization at any time by submitting a written request to my/my child(ren)'s Primary Care Physician or to the Medical Records Supervisor at Pediatric Associates Inc., of Brockton. Authorization may be revoked except for the following:
  - to the extent that action has been taken in reliance on this authorization
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be effected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Pediatric Associates Inc., of Brockton.
- I understand that this authorization will automatically expire in **180 days or otherwise as indicated:**

 upon a specific event or date (specify event or date)_____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed.

Patient's Signature:_____ Date:_____

When a patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative:_____ Date:_____

Print Name:_____

Relationship of representative to patient:_____