AUTHORIZATION

# Release of Medical Records

Pediatric Associates of Malden
Boston Children's
Primary Care Alliance

pediatricassociatesofmalden.com
781-322-5101 | *fax* 781-322-5820

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 Pediatric Associates of Malden 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:**

❍ 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: _____

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

Name: _____

Organization _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

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 (se ually 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 Pediatric Associates of Malden to share this type of information. I understand that if I do not initial the box, Pediatric Associates of Malden will not share this information about me/the patient's health to the person or organization listed above.

**HIV test results**
(Specific patient authorization required for each release request)

Specify dates: _____
Initial if info **may be shared**: _____

**Genetic screening test results** (Specify type of test):

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

**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 if info **may be shared**: _____

**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 shared**: _____

**Confidential Communications with a Licensed Social Worker**
Initial if info **may be shared**: _____

**Information related to the use of alcohol, drugs, and/or tobacco**
Initial if info **may be shared**: _____

**Information related to a sexually transmitted disease, sexual activity and/or orientation**
Initial if info **may be shared**: _____

**Information related to diagnosis or treatment of pregnancy**
Initial if info **may be shared**: _____

**Information related to child abuse or neglect**
Initial if info **may be shared**: _____

**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info **may be shared**: _____

**Other(s):** Please list: _____
Initial if info **may be shared**: _____

I know I can revoke this form at any time. This means I can tell Pediatric Associates of Malden to stop sharing my/the patient's information. I know I cannot withdraw information that Pediatric Associates of Malden had shared before I told Pediatric Associates of Malden to stop. Pediatric Associates of Malden may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to Pediatric Associates of Malden telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Pediatric Associates of Malden 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):

_____

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.

## Reason for release (optional):

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. Pediatric Associates of Malden 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.