AUTHORIZATION

Release of Medical Records

Commonwealth Pediatrics
Boston Children's
Primary Care Alliance

commonwealthpediatrics.com
781-451-0072 | *fax* 781-435-0792

Patient information

Last name: _____

First name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Date of birth: _____

I hereby authorize (name of person or facility that has information):

Name/facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

To release to (name of person or facility to receive information):

Name/facility: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information to be released:

I give permission for the above named practice to my/the patient's medical record with the person or organization listed above to receive the information. 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:

❍ Summary (includes immunizations, last two well visits and last year of notes)

❍ Medical Record (except confidential information defined by Massachusetts law)

❍ Medical Record inclusive of the following dates:

From: _____ To: _____

❍ Only information from a certain illness or injury (please describe):

_____

Please initial all parts you **AGREE** to have shared:

Under Massachusetts privacy laws, a separate consent is needed to share information about certain topics. By putting my initials by each item below I give permission for the practice named above to share this type of information. I understand that if I do not initial the box, the practice named above will not share this information about me/the patient's health to the person or organization listed above.

	Initials
HIV/AIDS Testing or Treatment	_____
Behavioral / Mental Health Information	_____
Genetic Screening Test Results	_____
HIV Test results (Specific approval required for each release request.)	
Specify dates: _____	_____
Sexual Health or Pregnancy Information	_____
Social Work Notes	_____
Substance Use/Abuse Information	_____
Information related to child abuse or neglect; family violence and/or domestic violence	_____
Other(s)	_____

Please list: _____

I know I can revoke this form at any time. This means I can tell the practice named above to stop sharing my/the patient's information. I know I cannot withdraw information that the practice had shared before I told them to stop as they may have already shared it. If I no longer want my/the patient's medical record shared I will send a written letter to the practice telling them to stop. This approval will end in 12 months or sooner if I send a written letter to the practice named above telling them to revoke this form.

Signature

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 (if patient is under 13):

_____ Date: _____

Signature of patient (if over 13*):

_____ Date: _____

* Under Massachusetts law, patients between the ages of 13 and 18 may be allowed to provide or decline release without parental consent. Patients over 18 must sign the form themselves.