CONSENT FORM

Disclosure of Clinical Information to an Outside Provider

Neponset Valley Pediatrics
Boston Children's
Primary Care Alliance

neponsetvalleypediatrics.com
781-784-0403 | *fax* 781-784-0407

Patient last name:_____

First name: _____ MI: _____

Patient date of birth: _____

Patient address: _____

City: _____ State: _____ Zip: _____

Authorization

I authorize Neponset Valley Pediatrics to communicate with the following providers, as needed, to help with evaluation, treatment planning, and coordination of care:

Name: _____

Organization _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Neponset Valley Pediatrics has my permission to release information acquired in the course of evaluation and/or treatment of the above named patient, including telephone contact and secure email. I understand the information may include the items initialed below (if applicable).

Please initial all elements you **agree** to have released:

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**: _____

In addition, I give permission to the medical and behavioral health providers of Neponset Valley Pediatrics to share information with any emergency caregivers who are involved in the care of my child in the event of a medical or psychiatric emergency.

This authorization is voluntary and I have the right to refuse to sign it. Signing this form is not a condition of treatment.

I may take back this authorization at any time by giving written notice of revocation; however such revocation would not affect any action taken by Neponset Valley Pediatrics in compliance with this authorization before receipt of my written, hard-copy, revocation.

You may accept photocopies or facsimiles of this authorization.

This authorization will expire in 12 months from the date of signing, unless otherwise changed or revoked.

Signature of parent/guardian/self (if 13+)

Signature:_____

Date: _____

Staff signature: _____

You have the right to have a copy of this form after you sign it. The original of this form will become part of the clinical record.

STAFF USE ONLY Verbal Consent

Obtained from: _____

Date: _____ Time: _____ ☐ Via phone ☐ In-person

Name of parent/guardian/patient (if 13+):

_____

Witness name: _____ Title: _____

Signature: _____