# Authorization for the Release of Medical Information and Records

Lexington Pediatrics
Boston Children's
Primary Care Alliance

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## Patient information

Patient last name: _____

First name: _____ MI: _____

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 share 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 for the time 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.

**NOTE: If the patient is 13 years or older,** they need to initial below if they choose to release this information. Please initial all parts you agree to have shared.

**HIV/AIDS Testing or Treatment**

Initial: _____

**Behavioral/Mental Health Information**

Initial: _____

**Genetic Screening Test Results**

Initial: _____

**HIV Test results** (Specific approval required for each release request.)

Specify dates, from: _____ to: _____

Initial: _____

**Sexual Health or Pregnancy Information**

Initial: _____

**Social Work Notes**

Initial: _____

**Substance Use/Abuse Information**

Initial: _____

**Information related to child abuse or neglect; family violence and/or domestic violence**

Initial: _____

Other(s), please list:

_____

_____

_____

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## Authorization

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.

**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.