AUTHORIZATION

Disclosure of Behavioral Health Clinical Information

Pediatrics at Newton Wellesley, P.C.
Boston Children's
Primary Care Alliance

pedinw.org
617-969-8989 | *fax* 617-928-0178

Patient name: _____

Date of birth: _____

I authorize Pediatrics at Newton Wellesley, P.C. to communicate with the following providers, as needed, to help with evaluation, treatment planning and coordination of care:

Person/Agency #1: _____

Phone: _____ Fax: _____

Email: _____

Role (select one):
❍ Therapist
❍ Medication prescriber
❍ School personnel
❍ Other: _____

Person/Agency #2: _____

Phone: _____ Fax: _____

Email: _____

Role (select one):
❍ Therapist
❍ Medication prescriber
❍ School personnel
❍ Other: _____

Person/Agency #3: _____

Phone: _____ Fax: _____

Email: _____

Role (select one):
❍ Therapist
❍ Medication prescriber
❍ School personnel
❍ Other: _____

Person/Agency #4: _____

Phone: _____ Fax: _____

Email: _____

Role (select one):
❍ Therapist
❍ Medication prescriber
❍ School personnel
❍ Other: _____

Authorization

Pediatrics at Newton Wellesley, P.C. has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient, including telephone contact.

Email authorization
Pediatrics at Newton Wellesley, P.C. has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient via email. ❍ No ❍ Yes

Please check the protected health information below that you are authorizing to be used and/or disclosed:

❑ Social/Family history
❑ School related information
❑ Neuropsychological reports
❑ ER visits/Hospitalizations
❑ Alcohol and substance abuse/treatment*
❑ HIV/AIDS related*
❑ Information related to a sexually transmitted infection, sexual activity and/or orientation
❑ Other(s), please list:

_____

*HIV and Substance Abuse information is protected under federal law and must be authorized specifically in order to be use/disclosed.

This authorization will expire with the completion of treatment, unless otherwise changed and/or revoked.

I understand that I may revoke this consent at any time, and that I must notify Pediatrics at Newton Wellesley, P.C. in writing. I understand that such a revocation does not affect any action taken by Pediatrics at Newton Wellesley, P.C. prior to receiving my written notice.

Signature

Signature of parent/legal guardian, or patient if 13 or over:

_____

Printed name: _____

Date: _____

Acknowledgement of electronic signature: ❍ No ❍ Yes