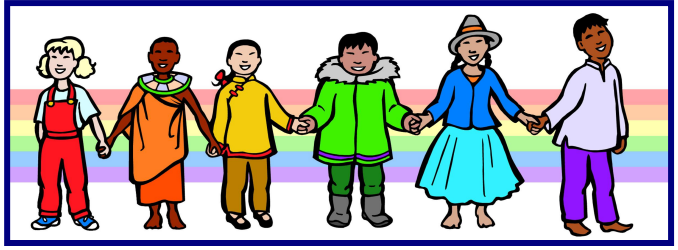
Pediatric Associates of Medford
101 Main Street, Suite 201
Medford, MA 02155
(781) 396-1288
www.medfordmedi.com



Authorization for the Release of Medical Records

Demographics

Patient Last Name _____ First Name _____ MI_____

Patient Date of Birth _____

Patient Address _____

Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for *Practice Name* 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 _____

Email Address _____

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 (sexually 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 *Practice Name* to share this type of information. I understand that if I do not initial the box, *Practice Name* will not share this information about me/the patient's health to the person or organization listed above.

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Initial if info **may** be shared	**HIV test results** (Specific approval 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**

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

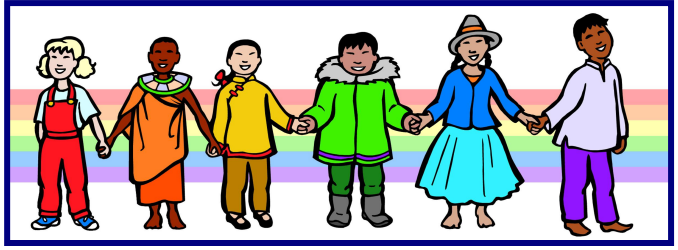
This approval will end in 12 months or sooner if I send a written letter to *Practice Name* telling them to revoke this form. ***Cost for medical records is $15.00 per patient with maximum family cost of $30.00***.

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 /Self (if 13+) Date



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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. *Practice Name* 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.