Pediatric Health Care Associates P.C.

Signed form may be faxed to:
978-535-5910, or mailed to:
Pediatric Health Care Associates
10 Centennial Drive
Peabody, MA

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Please complete this form and sign on page 2 where indicated.

If you have questions related to this form contact us at 978-535-1110

Demographics

Patient Last Name _____ **First Name** _____ **MI** ____
Home Street Address _____ **Apt#** _____
City _____ **State** _____ **ZIP** _____
Children's MR# _____ **Home Telephone** _____
Date of Birth _____ **Alternate Telephone** _____
Email _____

I authorize Pediatric Health Care Associates to ☐ release or ☐ obtain (check one) my/my child's protected health information including copies of my medical record of care to the following person(s) at the address/facility listed below:

Name/Facility	
Attention	**Telephone**
Address Suite/Room	**Fax**
City/State	**ZIP**

PURPOSE OF RELEASE (check the appropriate box below)

☐ Medical Care ☐ Insurance ☐ Legal Matter
☐ School or Camp ☐ Personal
☐ Dissatisfied with Services (please comment below)
_____
☐ Other (please specify)
_____

FORMAT OF RELEASE
(please check the appropriate box below)
☐ Paper
☐ Electronic

INFORMATION REQUESTED
DATE RANGE for information needed: _____

☐ Entire Medical Record (charges may apply)
☐ Medical Record Abstract (e.g. History & Physical, Consults, Test Reports, Discharge Summary) (last 2 years)
☐ Labs X-ray Reports
☐ Sick Visits
☐ Immunizations/Vaccines
☐ Other – Specify information to be released: _____
_____
_____
_____

SEE PAGE 2 ON REVERSE SIDE
Please complete both sides of this form and sign and date at the bottom of page 2

PEDIATRIC HEALTHCARE ASSOCIATES, 10 CENTENNIAL DR, PEABODY, MA 01960

Pediatric Health Care Associates has my permission to release information contained in the medical record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child's medical record):

PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED

Initial if info may be released	**HIV test results** (SPECIFIC PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) SPECIFY DATES:
Initial if info may be released	**Genetic Screening Test Results** (SPECIFY TYPE OF TEST)
Initial if info may be released	**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 DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART2. I can, however, cancel this authorization in writing at any time, except to the extent that PHCA has relied upon it.
Initial if info may be released	**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 released	**Confidential Communications with a Licensed Social Worker**
Initial if info may be released	**Information related to a sexually transmitted disease**
Initial if info may be released	**Information related to diagnosis or treatment of Hepatitis**
Initial if info may be released	**Information related to diagnosis or treatment of Pregnancy**
Initial if info may be released	**Information related to spouse abuse and/or child abuse or neglect**
Initial if info may be released	**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info may be released	**Contain information regarding rape and/or Sexual Assault Counseling**
Initial if info may be released	**Other(s): Please List**

I hereby authorize Pediatric Healthcare Associates (PHCA) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that PHCA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHCA may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. The authorization will expire 12 months from the signature date, unless otherwise specified: ___/___/___ I can, however, cancel this authorization in writing at any time, except to the extent that PHCA has relied upon it. For example, if I cancel it after PHCA has sent the requested records, PHCA will not retrieve those records. Instructions for canceling this authorization are included in the Pediatric Healthcare Associates Notice of Privacy Practices.

I understand that PHCA will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.

Signature of Patient	**Name of Patient (please print)**	**Date**
Signature of Parent or Guardian	**Relation to Patient**	**Date**