Pediatrics at Newton Wellesley

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Authorization for Disclosure of Clinical Information

Patient Name: _____ DOB: _____

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	**Role** (check one)	**Phone/Fax/Email (if applicable)**
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	

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 and email (if applicable please indicate if consenting to email communication ❑ yes ❑ no). Please check the protected health information below that you are authorizing to be used and/or disclosed:

❑ Details of Mental Health Diagnosis and/or Treatment provided by a Mental Health Provider

❑ 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 of Patient (or Parent/Guardian) Date

_____

Printed Name