HOLYOKE PEDIATRIC ASSOCIATES

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Authorization for the Release of Medical Records

Demographics

Patient Last Name _____ First Name _____ MI_____

Patient Date of Birth _____ Patient Phone Number _____

Patient Address _____

Authorization

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

I give my permission for *Holyoke Pediatrics* to receive/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.

Reason for requesting/releasing Medical Record: ☐ Transferring in ☐ Transferring out
☐ Medical care ☐ School ☐ Legal

Documents being requested:

☐ Entire Medical Record (except confidential information defined by Massachusetts law)
☐ Medical Record for a specific time period: from _____to _____
☐ Only information from a certain illness or injury: Please describe- _____

☐ I authorize Holyoke Pediatrics to release my/the patient's records to another facility.
☐ I authorize other facilities to release my/the patient's record to Holyoke Pediatrics.
☐ I authorize verbal communication with Holyoke Pediatrics.

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 sexually transmitted or other communicable disease(s)
- Results of tests for HIV/AIDS

Please initial all parts you <u>agree</u> to have shared.

By putting my initials by each item below I give permission for *Holyoke Pediatrics* to receive/share this type of information. I understand that if I do not initial the box, *Holyoke Pediatrics* will not receive/share this information about me/the patient's health to the person or organization listed above.

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 *Holyoke Pediatrics* to stop sharing my/the patient's information. I know I cannot withdraw information that *Holyoke Pediatrics* had shared before I told *Holyoke Pediatrics* to stop. *Holyoke Pediatrics* may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to *Holyoke Pediatrics* telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to *Holyoke Pediatrics* 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 /Self (if 13+) Date

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Important Notice

You do not have to give permission to share these records. Holyoke Pediatrics 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.

Revised July 2022