Pediatric Associates of Wellesley, Inc

PERMISSION FORM
RELEASE OF MEDICAL INFORMATION

IN EFFECT FOR ONE YEAR OR LESS

(Patients age 18 and older)

TODAY'S DATE_____ BEST CONTACT PHONE # _____

MY NAME IS: _____DATE OF BIRTH _____
PRINT FULL NAME

I GIVE PERMISSION FOR:

_____
PRINT FULL NAME RELATIONSHIP

And/Or _____
PRINT FULL NAME RELATIONSHIP

TO DISCUSS AND HAVE ACCESS TO THE HEALTH INFORMATION THAT IS FOUND IN MY *PEDIATRIC ASSOCIATES'* MEDICAL RECORD.

INCLUDING ALL MY information (exchanged verbally or in writing) regarding my health and Medical care from the following personnel: (check all that apply)

___Physicians/Providers ___Nurses ___Medical Records Staff

___Billing Staff ___Administration

With the EXCEPTION of ANY of the following:
INITIAL ANY THAT YOU DO **NOT** WANT RELEASED TO PERSON LISTED ABOVE

____ HIV diagnosis, test results, treatment Specify date(s) _____
____ Information relating sexually transmitted diseases (testing, treatment, etc.)
____ Alcohol and Drug Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2
____ Psychotherapy notes recorded by a mental health professional documenting or analyzing the contents of conversation(s) during private, joint, group or family counseling session(s)
____ Other records of professional services by licensed Psychologists or Social Workers
____ Domestic Violence and/or Sexual Assault Victims' Counseling
____ Child Abuse, DSS and/or DYS documents and records
____ Educational testing and reports
____ OTHER (PLEASE SPECIFY) _____
_____

THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE YEAR FROM DATE OF FORM.

UNLESS: _____I REVOKE it in WRITING OR: ____ STOP on this date: _____

XX_____
SIGNATURE OF PATIENT AGE 18 + DATE

PAW FILE