Amherst Pediatrics, LLP
31A Hall Drive Suite 2 * Amherst, MA 01002
Phone: (413) 253-3773 * Fax: (413) 256-0215
www.amherstpeds.com

Authorization for the Release of Medical Records

Demographics

Patient Last Name ______________________________ First Name ______________________ MI_____

Patient Date of Birth_____________________________ Patient Phone ___________________________

Patient Address ____

Authorization

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

I give my permission for **Amherst Pediatrics** to **OBTAIN** my/the patient's medical record from 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- ________________________

****Amherst Pediatrics utilizes EPIC for our EHR.**
If records are available in Care everywhere, please check here: ( )
Those records not available through Care Everywhere, please fax or mail to Amherst Pediatrics.**

Send a copy of my/the patient's medical records from:

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 the above organization to share this type of information. I understand that if I do not initial the box, the above organization will not share this information about me/the patient's health to Amherst Pediatrics.

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**

This approval will end in 12 months or sooner if I send a written letter to Amherst 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.