MIDDLEBORO PEDIATRICS

2 LAKEVILLE BUSINESS PARK, LAKEVILLE, MASSACHUSETTS 02347 TEL (508) 947-0630 FAX (508) 947-0639

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AUTHORIZATION FOR RELEASE OF INFORMATION TO MIDDLEBORO PEDIATRICS

PATIENT INFORMATION:

Patient Name:_____ Date of Birth:_____

Address:_____

Daytime phone #:_____ Evening phone #:_____

RELEASE INFORMATION TO:

Name: Middleboro Pediatrics

Address: 2 Lakeville Business Park, Lakeville, MA 02347

Phone #: (508) 947-0630

RELEASE INFORMATION FROM:

Name:_____

Address:_____

Phone #:_____

PURPOSE OF REQUEST:

____ Transferring all care to a new physician
____ Specialty Care/Consultation/Second Opinion
____ Personal Use
____ Insurance
____ Legal
____ Other (please specify):_____

INFORMATION TO BE RELEASED (please specify dates):

___ Complete Medical Record
___ Immunizations and last physical ___ X-rays/Reports - Specify Dates:_____
___ Complete office record ___ Laboratory reports - Specify dates:_____
___ Other (please specify):_____

DATE NEEDED:

___ Normal processing time 2-3 weeks ___ Future appointment date:_____
___ Other (please specify):_____

AUTHORIZATION/DISCLOSURE:

We will not release information from other facilities or health care providers. Please contact them directly for information.

I request the release of the specifically protected or privileged categories of information that I have *INITIALED* below:

_____ HIV test results **(**PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
SPECIFY DATE(S)_____

_____ Alcohol and Drug Abuse 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 OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ Other(s): Please List _____

(Continued on other side)

I request the release of the specifically protected or privileged categories of information that I have *INITIALED* below:

Confidential Details of:

_____ Psychotherapy notes (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling, and that are separate from the medical record)

_____ Other professional services of a licensed psychologist

_____ Social Work Counseling/Therapy

_____ Domestic Violence Victims' Counseling

_____ Sexual Assault Counseling

I **understand that:**

- I may withdraw my authorization at any time by submitting a written request to the Office Manager at Middleboro Pediatrics. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization.
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient, and no longer protected by this rule.
- I understand that this authorization will remain in effect unless a time of expiration is specified below or this authorization is revoked in writing.
- **If you wish this authorization to expire automatically, please check the appropriate box below:**
  - **G** in 3 months
  - **G** in 6 months
  - **G** 1 year from this date
  - **G** upon a specific date or event ***(specify event)*** **_____**

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above. I release Middleboro Pediatrics, PC and its physicians and staff from all legal liability that may arise from the release of this information.

Patient's Signature: _____ Date: _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ Date: _____

Print Name: _____

Relationship of representative to patient: _____