



AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION Page 1 of 2

Please complete this form and sign on page 2 where indicated.
 If you have questions related to this form contact us at 978-535-1110

Return **signed** form to PHCA:

MAIL: Pediatric Health Care Associates
 10 Centennial Drive
 OR Peabody, MA 01960

FAX: 978-535-5910

Patient Demographics

Patient Last Name _____	First Name _____	MI _____
Date of Birth _____	Email _____	
Home Street Address _____		Apt# _____
City _____	State _____	ZIP _____
Primary Telephone _____		Secondary Telephone _____

Purpose of form: <input type="checkbox"/> Release to <input type="checkbox"/> Obtain from I authorize Pediatric Health Care Associates to release/obtain my/my child's protected health information including copies of my/their medical record of care to/from the following person(s) at the address/facility listed below.	
Name / Facility: _____	
Provider Name: _____	
Send Attention to: _____	Telephone: _____
Address Suite/Room: _____	Fax: _____
City/State: _____	ZIP: _____
PURPOSE OF RELEASE (check the appropriate box below) <input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance <input type="checkbox"/> Legal Matter <input type="checkbox"/> School or Camp <input type="checkbox"/> Personal <input type="checkbox"/> Dissatisfied with Services (please comment below) _____ <input type="checkbox"/> Other (please specify) _____	
FORMAT OF RELEASE (please check the appropriate box below) <input type="checkbox"/> Paper <input type="checkbox"/> Electronic <input type="checkbox"/> USB <input type="checkbox"/> Email _____	

INFORMATION REQUESTED	
DATE RANGE for information needed:	From Date _____ To Date _____
<input type="checkbox"/> Entire Medical Record (charges may apply) <input type="checkbox"/> Medical Record Abstract (e.g. History & Physical, Consults, Test Reports, Discharge Summary) (last 2 years) <input type="checkbox"/> Labs X-ray Reports <input type="checkbox"/> Sick Visits <input type="checkbox"/> Immunizations/Vaccines <input type="checkbox"/> Other – Specify information to be released: _____ _____ _____ _____	

Please complete both sides of this form and SIGN and DATE at the bottom of page 2

Pediatric Health Care Associates has my permission to release information contained in the medical record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child’s medical record): PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED	
Initial if info may be released	HIV test results (SPECIFIC PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) SPECIFY DATES:
Initial if info may be released	Genetic Screening Test Results (SPECIFY TYPE OF TEST)
Initial if info may be released	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 DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. I can, however, cancel this authorization in writing at any time, except to the extent that PHCA has relied upon it.
Initial if info may be released	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 released	Confidential Communications with a Licensed Social Worker
Initial if info may be released	Information related to a sexually transmitted disease
Initial if info may be released	Information related to diagnosis or treatment of Hepatitis
Initial if info may be released	Information related to diagnosis or treatment of Pregnancy
Initial if info may be released	Information related to spouse abuse and/or child abuse or neglect
Initial if info may be released	Information concerning family violence and/or Domestic Violence Victims’ Counseling
Initial if info may be released	Contain information regarding rape and/or Sexual Assault Counseling
Initial if info may be released	Other(s): Please List

I hereby authorize Pediatric Healthcare Associates (PHCA) to release any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that PHCA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at PHCA may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. The authorization will expire 12 months from the signature date, unless otherwise specified: ___/___/___ I can, however, cancel this authorization in writing at any time, except to the extent that PHCA has relied upon it. For example, if I cancel it after PHCA has sent the requested records, PHCA will not retrieve those records. Instructions for canceling this authorization are included in the Pediatric Healthcare Associates Notice of Privacy Practices.

I understand that PHCA will continue to provide care, even if I do not authorize this release.

<i>Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.</i>		
_____ Signature of Patient	_____ Name of Patient (please print)	_____ Date
_____ Signature of Parent or Guardian	_____ Relation to Patient	_____ Date