Boston Children's Hospital
Until every child is well™

Adolescent Substance Use and Addiction Program

Completing Authorization for Release of Medical Records Information:

The purpose of the Authorization for Release of Medical Records Information is to allow ASAP providers to coordinate care with professionals involved in a patient's care outside of Boston Children's Hospital.

Coordinating care allows us to provide the best possible treatment to our patients and families. In order to communicate with or receive information from an outside professional, written consent is required.

They must be completed fully including signature and date (please see instructions below).

Completing these forms prior to the visit will help to ensure that your appointments are kept on schedule.

Please complete authorization forms for:

- Parent/Caregiver, if patient is over 18
- PCP
- Therapist/Counselor/Psychologist
- Psychiatrist
- Probation Officer
- DCF/DYS worker
- School counselor/guidance counselor, if appropriate
- Anyone else involved patient care that would be able to provide relevant and useful information or to whom it would be relevant and useful for ASAP providers to communicate.

(Please see back for further Instructions)

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Instructions for filling out Authorization Forms:

Please Note: A separate authorization form must be completed for each provider/professional.

PAGE 1:

1. Demographics:
    - Please complete all information in the demographics box

2. Name/Facility; Attention; Telephone; Address; Fax; City/State; Zip
    - This section is for the provider/professional for which you are allowing ASAP to communicate with. Please provide all information and specify in parenthesis the type of provider next to their name - e.g. Name/Facility: *John Smith (Therapist)*

3. Purpose of Release:
    - If completing for PCP, please check of the box labeled "Insurance" and the box labeled "Other"; for all other providers, please only check the box labeled "Other"
    - On the line please write: *Coordination of Care*

4. Format of Release:
    - Please check all three boxes: CD, Paper, Fax, add Phone.

5. Information Requested:
    - Please check the box labeled "Other"
    - On the lines, please write: *Substance Abuse Evaluation, Treatment Planning and Progress*

PAGE 2:

1. Please initial the following boxes:
    - Alcohol and Drug Abuse Treatment Records
    - Details of Mental Health Diagnosis and/or Treatment provided by…
    - Confidential Communications with a Licensed Social Worker

2. Please sign and date the appropriate line(s) at the bottom of the form