Medical Records Release Authorization

Lexington Pediatrics
Boston Children's Primary Care Alliance
lexpeds.com
781-862-4110

Patient Information:

Last name: _____ First name: _____ Middle initial: _____

Address _____

Telephone: _____ Date of Birth: _____

I hereby authorize (name of person or facility that has information):

Name/facility: _____

Address: _____

Phone: _____ Fax: _____

To release to (name of person or facility to receive information):

Name/facility: _____

Address: _____

Phone: _____ Fax: _____

Information to be released:
I give permission for the above-named practice to share my/the patient's medical record with the person or organization listed above to receive the information. 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:

- ○ Summary (includes immunizations, last two well visits and last year of notes)
- ○ 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: _____

Please initial all parts you agree to have shared:
Under Massachusetts privacy laws, a separate consent is needed to share information about certain topics. By putting my initials by each item below I give permission for the practice named above to share this type of information. I understand that if I do not initial the box, the practice named above will not share this information about me/the patient's health to the person or organization listed above.

Initial if info may be shared	**HIV/AIDS Testing or Treatment**
Initial if info may be shared	**Behavioral / Mental Health Information**
Initial if info may be shared	**Genetic Screening Test Results**
Initial if info may be shared	**HIV Test results** (Specific approval required for each release request.) Specify dates:
Initial if info may be shared	**Sexual Health or Pregnancy Information**
Initial if info may be shared	**Social Work Notes**
Initial if info may be shared	**Substance Use/Abuse Information**
Initial if info may be shared	**Information related to child abuse or neglect; family violence and/or domestic violence**
Initial if info may be shared	**Other(s): Please list**

I know I can revoke this form at any time. This means I can tell the practice named above to stop sharing my/the patient's information. I know I cannot withdraw information that the practice had shared before I told them to stop as they may have already shared it. If I no longer want my/the patient's medical record shared I will send a written letter to the practice telling them to stop. This approval will end in 12 months or sooner if I send a written letter to the practice named above 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 (if patient is under 13) Date

_____ _____
Signature of Patient (if over 13**) Date

**Under Massachusetts law, patients between the ages of 13 and 18 may be allowed to provide or decline release without parental consent. Patients over 18 must sign the form themselves.