

# Disclosure of Protected Health Information



If the patient is less than 18 years of age, this form must be completed by a parent or legal guardian.

If the patient is 13–17 years of age, the patient must sign and date the "Disclosure of sensitive information" section to authorize release of this information.

If the patient is 18 years of age or older, this form must be completed by the patient.

- Please be aware that we may require up to three weeks to processes any and all medical record requests.
- Excessive requests for medical records may result in a fee of \$0.72 per page for the first 100 pages and \$0.34 per page for each additional page.
- We are not able to email records.

## Patient information

First name: \_\_\_\_\_

Last name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

PCP: \_\_\_\_\_

## How would you like to receive your records?

Choose one:  CD  USB  Fax

## Reason for disclosure

Transferring care to another provider, your account will be inactivated.

Date: \_\_\_\_\_

Reason for transfer: \_\_\_\_\_

Other reason, your account will stay active.

Please specify: \_\_\_\_\_

## Information to be disclosed to

Complete medical records will be mailed via USPS or faxed. They will NOT be emailed. This may be your home address or your provider's address.

Name/facility: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Information to be disclosed

Entire Medical Record

Record covering only the following dates:

From: \_\_\_\_\_ To: \_\_\_\_\_

Other, please specify: \_\_\_\_\_

## Re-release of information

I authorize Longwood Pediatrics, LLP to re-release records from other physicians or facilities that may be included in the medical record (example: letters from consultants).

## Disclosure of sensitive information

HIV/AIDS testing or treatment.....  Yes  No

Social work notes.....  Yes  No

Pregnancy/Sexual health.....  Yes  No

Mental/Behavioral health information.....  Yes  No

Substance use/abuse .....  Yes  No

Patient signature (if 13 or over): \_\_\_\_\_

Date: \_\_\_\_\_

## Signature

I authorize Longwood Pediatrics, LLP to release all medical information as requested above. Information will not be released without a valid signature. I understand that I may revoke this authorization by submitting written notice of revocation to Longwood Pediatrics, LLP. This authorization will automatically expire 365 days from the signature date.

Parent/Guardian if patient is under 18:

\_\_\_\_\_

Relation to patient: \_\_\_\_\_

Patient, if 18 or older: \_\_\_\_\_

Date: \_\_\_\_\_