AUTHORIZATION

Disclosure of Protected Health Information

Longwood Pediatrics
Boston Children's
Primary Care Alliance

longwoodpeds.com
617-277-7320 | *fax* 617-277-7834

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

Patient name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax (required): _____

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: _____