Authorized Representative Form

Westwood-Mansfield Pediatrics
Boston Children's
Primary Care Alliance

Westwood 781-326-7700
Mansfield 508-339-9944
Easton 508 535-5535

wmpeds.com

This form is used to confirm a Patient/Parent's permission that the Health Plan/Provider may discuss or disclose their Protected Health Information (PHI) to a particular person(s) who acts as their Authorized Representative. Examples of an Authorized Representative may include:

- Mother/Father of 18 year old or older
- Grandparent
- Nanny or Caregiver
- Aunt/Uncle

Section A: Patient information

Please list all children that come to the practice.

By signing this form, I understand and agree that Westwood-Mansfield Pediatrics may release or discuss my child's personal health information (PHI) as described in Section B below to my Authorized Representative(s) named in Section C.

Patient name: _____

Date of birth: _____

Address: _____ Apt #: _____

City: _____ State: ___ Zip: _____

Phone: _____

Email: _____

Patient name: _____

Date of birth: _____

Address: _____ Apt #: _____

City: _____ State: ___ Zip: _____

Phone: _____

Email: _____

Patient name: _____

Date of birth: _____

Address: _____ Apt #: _____

City: _____ State: ___ Zip: _____

Phone: _____

Email: _____

Note: This authorization does not provide your, "Authorized Representative" with any authority, either implied or direct, over any treatment or direct care decisions. By signing this form, it simply gives permission to discuss personal health information. The Health Plan/Provider will not condition treatment, benefit payments, enrollment, or eligibility for benefits on the execution of this form.

Section B: Type of information

- Personal Health Information (PHI), including but not limited to, identification of treating providers of care, diagnoses, procedures, demographic information
- This information may include diagnose and/or treatment for alcohol and/or drug abuse; AIDS/AIDS Related Complex (ARC) and HIV diagnosis and/or treatment and diagnosis and/or treatment relating to other communicable diseases
- This authorization does not cover disclosure of psychotherapy notes

Section C: Authorized use and/or disclosure

Intended use and/or disclosure

I understand that the Health Plan/Provider's general policy is not to disclose my child's personal health information to other parties, except those directly involved in his/her care, without my written authorization or as permitted or required by law. For this reason, I authorize you to discuss and disclose my child's personal health information to the person(s) named below for the purpose of assisting with or facilitating the coordination of payment of health plan benefits or care and treatment of my child. I also understand that if my Authorized Representative is not a health care provider or another entity subject to federal or applicable state privacy laws, my child's personal health information may no longer be protected by those privacy laws and my child's personal health representative may further disclose my child's personal health information without my authorization. I acknowledge that my authorization is voluntary.

NEXT PAGE >

Authorized Representatives:

Name: _____

Relationship: _____

Contact phone: _____

Name: _____

Relationship: _____

Contact phone: _____

Name: _____

Relationship: _____

Contact phone: _____

Name: _____

Relationship: _____

Contact phone: _____

I understand that I have the right to limit the information that you release under this authorization. For example, I may limit my child's Authorized Representative's access to information about particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating **NO LIMITATIONS ON DISCLOSURE.**

Limitations on Disclosure:

_____

_____

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Section D: Expiration and revocation

I understand that I have the right to revoke or end this authorization at any time. I understand that, if I do not wish the person(s) named in Section C to remain on my child's Authorization Representative(s), I must revoke the authorization in writing and deliver by hand or fax to contact person below accompanied by proper identification (driver's lic). I understand that my revocation of this authorization will not affect any action that you have taken, or any information that you have already released, based upon this authorization before you actually receive my request to revoke it.

Contact person: Carol O'Neill

Phone: 781-234-1931

Fax: 781-407-0097

Section E: Signature/Authorization

I have had full opportunity to read and consider the content of this Authorization Representative Form. I understand that by signing this form I am confirming my authorization that my health plan and Westwood-Mansfield Pediatrics providers and staff may use and/or disclose my child's PHI to the persons named in Section C for the purposes described above. I also confirm that a facsimile copy of this form is acceptable.

Signature: _____

Date: _____

Please return the signed Authorization Form to the front desk personnel or fax to contact person listed above in Section D. You are entitled to a copy of this Authorization Form after is it signed.