HOLYOKE PEDIATRIC ASSOCIATES, LLP

150 Lower Westfield Road
Holyoke, MA 01040
(413) 536-2393

84 Willimansett Street
South Hadley, MA 01075
(413) 532-0300

AUTHORIZATION TO REQUEST/RELEASE MEDICAL RECORDS

Re: ___________________________________ Address: _________________________________
DOB: _______________ _________________________________
Contact Phone: _________________________________

[ ] Request For Information FROM ANOTHER AGENCY:
I give my consent to release information to Holyoke Pediatric Associates from the medical/treatment record (including psychiatric and/or substance abuse information if applicable), maintained while I was a patient at/treated by: _____________________________________
_____________________________________ (Hospital, clinic, physician name and address)

[ ] Release of Information FROM HOLYOKE PEDIATRIC ASSOCIATES:
I give consent to Holyoke Pediatric Associates to release information from the medical record maintained while I was a patient at HPA during the period of : ___________ to:____________
Date(s)

______________________________ ____
(Name of Agency) (Address of Agency)

[ ] Release For Sensitive Information
I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric care, venereal disease, social service, hepatitis B testing, and/or sensitive information, I agree to its release.

____ _____________
Signature of Patient or Parent/Legal Guardian Date

[ ] Release of HIV Information
I understand that if my medical record contains information in reference to HIV (AIDS) testing/treatment I agree to its release.

____ _____________
Signature of Patient or Parent/Legal Guardian Date

The specific information to be disclosed is:

[ ] Office Notes
[ ] Physical Exams
[ ] Legal & Attorney Reports
[ ] Immunization Records
[ ] Other, Specify: ____
[ ] HPA Laboratory reports
[ ] Daycare Information
[ ] Nutrition Summaries
[ ] Camp
[ ] School

[ ] Consent to Disclose Protected Health Information to Parent/Guardian/Representative

I _________________________ give HPA permission to speak with and/or release

Information to ____

Signature ____ Date: ___________
Parent/Guardian/Representative

Information [ ] may [ ] may not be released via telephone.

HOLYOKE PEDIATRIC ASSOCIATES, LLP

AUTHORIZATION TO REQUEST/RELEASE MEDICAL RECORDS

[ ] Consent to treat

I_________________________________ give _____________________ permission
To make medical decisions and provide consent for treatment of my child.

____ **Date:** ________________
Signature of Parent/Legal Guardian

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken. I understand that further disclosure of the information to be released may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations. Part 2).

UNLESS OTHERWISE INDICATED THIS CONSENT WILL EXPIRE IN SIX (6) MONTHS.

____ **Date:** _____________
Signature of Patient

____ **Date:** _____________
Signature of Parent/Guardian/Legal Representative

____ **Date:** _____________
Signature of Witness **Relationship** ____

For HPA USE ONLY: Form of ID _______________________ **Copy Fee Collected $** __________

Billing [ ] ____ **Date:** __________
Staff Signature