
**150 LOWER WESTFIELD ROAD ● HOLYOKE, MASSACHUSETTS 01040 ● TELEPHONE (413) 536-2393**
**84 WILLIMANSETT STREET ● SOUTH HADLEY, MASSACHUSETTS 01075 ● TELEPHONE (413) 532-0300**

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**Holyoke Pediatric Associates FAX # (413) 536-1087**

Patient Name: D.O.B.

Home Street Address _____ Apt # _____

City _____ State _____ Zip code _____

Telephone HOME: ( ) _____ MOBILE: ( ) _____

- □ I request a copy or authorize Holyoke Pediatric Associates, LLP to release my/my child's protected Health Information including medical records to the following person(s) at the address/ facility listed below:
- □ I authorize other facilities to release records to Holyoke Pediatric Associates, LLP

Name/ Facility

Attention Telephone

Address Fax

City/State Zip

PURPOSE OF RELEASE ( check appropriate box below)

- □ Medical Care
- □ School
- □ Transfer of Care
- □ Legal
- □ Adolescent/Adult release to the Parent

I understand there may be a charge for the copying of these medical records.

INFORMATION TO BE RELEASED: DATE RANGE:_____

- □ Entire Medical Record
- □ Immunizations
- □ X-rays/reports
- □ Lab results
- □ Medical Record Abstract (e.g. History & Physical, Consults, Test results)
- □ Other (please specify):

**FORMAT OF RELEASE**

- □ **Paper**
- □ **Fax (to MD office only)**
- □ **Electronic**
- □ **Verbal**

**Authorization for release of Medical Records Information**

Holyoke Pediatric Associates, LLP has my permission to release/obtain information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child's medical record):

**PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED**

| | |
|---|---|
| | **HIV/AIDS Information** (Patient Authorization Required For Each Release Request) |
| | **Genetic Screening Test Results** (Specify type of Test) |
| | **Alcohol and Drug Abuse Treatment Records**<br>Federal rules prohibit any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I can however cancel this authorization in writing at any time, except to the extent that Holyoke Pediatrics Associates has relied upon it. |
| | **Details of Mental Health Diagnosis and /or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician.**<br>I understand that my permission may not be required to release my mental health records for payment purposes. |
| | **Confidential Communication with a Licensed Social Worker** |
| | **Information related to a sexually transmitted disease** |
| | **Information related to Diagnosis or treatment of Hepatitis** |
| | **Information related to Diagnosis or treatment of Pregnancy** |
| | **Information related to spouse abuse and/or child abuse or neglect** |
| | **Information concerning family violence and /or Domestic Violence Victims' Counseling** |
| | **Contain Information regarding rape and/or Sexual Assault Counseling** |
| | **Other(s): Please List** |

I hereby authorize Holyoke Pediatric Associates, LLP (HPA) to release/obtain any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that HPA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at HPA may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. **This authorization will expire 1 year** from the signature date, unless otherwise specified. I can, however, cancel this authorization in writing at any time, except to the extent that HPA has relied upon it. For example, if I cancel it after HPA has sent the requested records, HPA will not retrieve those records. I understand that HPA will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.

| _____ | _____ | _____ |
|---|---|---|
| **Signature of Patient** | **Name of Patient (Print)** | **Date** |
| _____ | _____ | _____ |
| **Signature of Patent or Guardian** | **Relationship to Patient** | **Date** |