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## Authorization for the Release of Medical Records

### Demographics

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Patient Address \_\_\_\_\_

### Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for *Holyoke Pediatrics* to receive/share my/the patient's medical record with the person or organization listed below. My/the patient's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

Reason for requesting/releasing Medical Record:  Transferring in  Transferring out  Legal  
 Medical care  School  Adolescent/Adult release to the parent

Choose one:

- Entire Medical Record (except confidential information defined by Massachusetts law)
- Medical Record for a specific time period: from \_\_\_\_\_ to \_\_\_\_\_
- Only information from a certain illness or injury: Please describe- \_\_\_\_\_

Send a copy of my/the patient's medical records to:

Name \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

Email Address \_\_\_\_\_

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

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (sexually transmitted) or other communicable disease(s)
- Results of tests for HIV/AIDS

**Please initial all parts you agree to have shared.**

By putting my initials by each item below I give permission for *Holyoke Pediatrics* to receive/share this type of information. I understand that if I do not initial the box, *Holyoke Pediatrics* will not receive/share this information about me/the patient's health to the person or organization listed above.

Initial if info may be shared	<b>HIV test results</b> (Specific approval required for each release request) Specify Dates:
Initial if info may be shared	<b>Genetic Screening Test Results</b> (Specify type of test)
Initial if info may be shared	<b>Alcohol and Drug Abuse Treatment Records</b> Protected by Federal Confidentiality Rules 42 CFR Part 2. 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.
Initial if info may be shared	<b>Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC).</b> I understand that my permission may not be required to release my mental health records for payment purposes.
Initial if info may be shared	<b>Confidential Communications with a Licensed Social Worker</b>
Initial if info may be shared	<b>Information related to the use of alcohol, drugs, and/or tobacco</b>
Initial if info may be shared	<b>Information related to a sexually transmitted disease, sexual activity and/or orientation</b>
Initial if info may be shared	<b>Information related to diagnosis or treatment of pregnancy</b>
Initial if info may be shared	<b>Information related to child abuse or neglect</b>
Initial if info may be shared	<b>Information concerning family violence and/or Domestic Violence Victims' Counseling</b>
Initial if info may be shared	<b>Other(s): Please list</b>

I know I can revoke this form at any time. This means I can tell *Holyoke Pediatrics* to stop sharing my/the patient's information. I know I cannot withdraw information that *Holyoke Pediatrics* had shared before I told *Holyoke Pediatrics* to stop. *Holyoke Pediatrics* may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to *Holyoke Pediatrics* telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to *Holyoke Pediatrics* telling them to revoke this form.

By signing below I agree that I understand the above and voluntarily allow my/the patient's medical record to be shared.

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Parent/Legal Guardian's Name (if applicable)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Parent /Legal Guardian /Self (if 13+)

\_\_\_\_\_  
Date

*Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.*

**Important Notice**

You do not have to give permission to share these records. *Holyoke Pediatrics* will not base your/the patient's treatment on whether or not you sign this form.

After your/the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to get a copy of this signed form.