NORTHAMPTON AREA PEDIATRICS, LLP

193 Locust Street
Northampton, MA 01060
Tel. (413) 584-8700
Fax (413) 584-1714
Bus. (413) 585-9047

AMANDA BARNHART, M.D.
PETER EVERETT, M.D.
KATHERINE KELLY, F.N.P.
MONIQUE PATTEN, F.N.P.
BETH SHAINE, P.N.P.

JANA CABLE, M.D.
DIANA JOHANSON, M.D.
PETER KENNY, M.D.
JONATHAN SCHWAB, M.D.
DAVID STEELE, M.D.

170 University Drive
Amherst, MA 01002
Tel. (413) 584-8700
Fax (413) 256-6069

Pediatric and Adolescent Medicine

AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION

Patient Name: _____ **Date of Birth:** _____

The following individual or organization is authorized to make the disclosure:

□ Northampton Area Pediatrics, LLP
□ Other (please specify) _____

The information will be disclosed to:

□ Parent/Guardian/Self_____
□ Northampton Area Pediatrics, LLP
□ Other (please specify) _____

Information to be disclosed:

□ All medical information
□ Limited information:
- □ Exam dates: _____
- □ Test results:_____
- □ Treatments:_____
- □ Other (please specify): _____

Reason for Request:

□ Transfer
□ Coordination of Care / Verbal or Written
□ Copy for self/guardian/parent
□ Other (please specify) _____

Please Send: □ Paper Copies

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Re-disclosure: I understand that any disclosure or information carries with it a potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: (If I do not specify an expiration date, event, or condition, this authorization will expire in five years.) **EXPIRATION DATE: _____**

_____ _____

Signature of Patient (if 18 years of age and over), Parent or Legal Representative **Today's Date**

If signed by legal representative, relation to patient: _____