Authorization for the Release of Medical Records

Demographics

Patient Last Name _____ First Name _____

Patient's Date of Birth _____

Reason for Release

- ☐ Transfer care out of NAP
- ☐ COC – other medical provider
- ☐ COC – Parent of patient age 18 years & older
- ☐ Copy for Self
- ☐ Copy for legal
- ☐ Other: _____

Send a copy of my/the patient's medical records to or provide coordination of care with:

Name of Organization or Individual: _____

Address: _____

Fax Number: _____ Phone Number: _____

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

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

Choose one:

- ☐ Medical Record (except confidential information defined by Massachusetts law)
- ☐ Medical Record for the time from _____to _____
- ☐ Only information from a certain illness or injury. Please Describe _____

Authorization for the Release of Medical Records

Please initial all parts you <u>agree</u> to have shared.
By putting my initials by each item below I give permission to Northampton Area Pediatrics to share this type of information. I understand that ***if I do not initial the box***, *Northampton Area Pediatrics* will not share this information about me/the patient's health to the person or organization listed above.

Initial if info **may** be shared	**HIV test results** (Specific approval required for each release request)
Initial if info **may** be shared	**Genetic Screening Test Results** (Specify type of test)
Initial if info **may** be shared	**Alcohol and Drug Abuse Treatment Records**
Initial if info **may** be shared	**Information related to the use of alcohol, drugs, and/or tobacco**
Initial if info **may** be shared	**Information related to a sexually transmitted disease, sexual activity and/or orientation**
Initial if info **may** be shared	**Information related to diagnosis or treatment of pregnancy**
Initial if info **may** be shared	**Information related to child abuse or neglect**
Initial if info **may** be shared	**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info **may** be shared	**Other(s): Please list**

I know I can revoke this form at any time. This means I can tell *Northampton Area Pediatrics* to stop sharing my/the patient's information. I know I cannot withdraw information that *Northampton Area Pediatrics* had shared before I told *Northampton Area Pediatrics* to stop. *Northampton Area 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 *Northampton Area Pediatrics* telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to *Northampton Area 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. *Northampton Area 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 receive a copy of this signed form.

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