NORTHAMPTON AREA PEDIATRICS, LLP

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Pediatric and Adolescent Medicine

Authorization to Release SENSITIVE Health Information

Patient Name: ____ **Date of Birth:** ________________________________

Authorization regarding sensitive information: To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check mark(s) below indicate(s) that **I PERMIT** information of this type, if it exists, to be released. I understand that if I do not check the box, such information about me will NOT be released if it exists.

☐ HIV/AIDS ☐ Treatment for alcohol and/or drug abuse

☐ Genetic Information ☐ Sexually Transmitted Diseases

I request and authorize **Northampton Area Pediatrics** to release protected health information of the patient named above to:

Name/Facility: ____

Address: ____

Phone Number: ____ Fax: _________________________________

Without my express revocation, I understand that this authorization will **expire 1 year from the date signed** unless indicated below:

Under the following condition(s):____

Upon satisfaction of the need for disclosure on ____
(enter a future date other than date signed by patient not to exceed 1 year)

I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment.

Guardian/Parent Signature: ____ Date Signed: ____________________

Relationship to Patient: ____

Patient Signature *(for pts 12+ yrs)* ____ Date Signed: ____________________

In accordance with Massachusetts teen privacy laws, patients 12 years and older must sign this form to provide consent for the release of sensitive health information.