NORTHAMPTON AREA PEDIATRICS, LLP

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

170 University Dr., Ste. 101
Amherst, MA 01002
Tel. (413) 584-8700
Fax (413) 256-6069

Pediatric and Adolescent Medicine

Authorization for Release of Information
Two Way
Behavioral Health

1. Patient Information

Name: _____ Date of Birth: _____

Street: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

2. **Authorization to Release:** I authorize Northampton Area Pediatrics to receive and release information, including confidential communications, from or to the Person, Agency, or Facility name below, either verbally or in writing.

Name: _____ Attention: _____

Street: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____

3. **Check to indicate the information you want shared:** (*check all that apply)*

☐ Mental Health Diagnosis and Treatment provided by a psychiatrist; psychologist; mental health clinical nurse specialist; licensed social worker counseling; all other licensed mental health providers.

☐ Entire Mental Health Record, excluding Psychotherapy Notes which require a separate authorization

☐ Entire Record (Medical and Mental Health)	☐ ISPs and IAPs	☐Treatment Plans
☐ Discharge Summary	☐ Neuropsych Testing	☐ Transfer Summary
☐ Admission Documentation	☐ Physical Exam	☐ Lab Reports

☐ Other (please specify) / additional information: _____

_____

4. Date of the information you want shared: *(specify dates)*

Dates of Requested Information: From : _____ To: _____

Northampton Area Pediatrics
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Patient Name: _____

5. Please initial to indicate you give permission to release the following information in present in your records: *(initial all that apply)*

Initial here: _____ HIV test results (Authorization required for each release request)

Initial here: _____ Alcohol and drug abuse records protected by federal confidentiality Rules 42 CFR Part 2 federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

6. Purpose of the Release: *(must check one)*

☐ Personal Use ☐ Coordinate Care ☐ Referral ☐ Facilitate billing

☐ Obtain insurance, financial or other benefits

☐ Other purpose *(please specify):* _____

I understand that:

- I have a right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing and present it to Northampton Area Pediatrics at 193 Locust St., Northampton MA 01060 or fax (413) 584-1714.
- The revocation will not apply to information that has already been released pursuant to this authorization.
- The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Once the above information is released, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations.
- Authorizing the disclosure of the information identified above is voluntary.
- I need not sign this form to receive treatment or services from NAP and/or the other named person, facility or agency; however, lack of ability to share or obtain information may prevent NAP, and/or the other named person, facility or agency, from providing appropriate and necessary care.

This authorization will expire (specify a date, time period or an event) _____ or, if nothing is specified, it will expire one year from date of signing.

7. Signature / Authorization: Sign and provide information as required below.

_____ _____

Your signature or personal representative's signature Date

_____

Print name of signer

The following information is needed if signed by a personal representative:
Type of authority (e.g. court appointed, custodial parent): _____