



Pediatric Associates of Medford
Boston Children's
Primary Care Alliance

101 Main Street Suite 202
Medford, MA 02155
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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 Pediatric Associates of Medford to 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.

Choose one:

- ☐ Medical Record (except confidential information defined by Massachusetts state law)
☐ Medical Record for the time 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/Practice: _____

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/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, on the next page, I give permission for **Pediatric Associates of Medford (PAM)** to share this type of information. I understand that if I do not initial the box, **PAM** will **not** share this information about me/the patient's health to the person/organization listed above.

Please initial ALL parts you agree to have shared.

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

Initial if info may be shared	HIV test results (Specific approval required for each release request) Specify which dates:
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 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	Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC). I understand that my permission may not be required to release my mental health records for payment purposes.
Initial if info may be shared	Confidential Communications with a Licensed Social Worker
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 Pediatric Associates of Medford (PAM) to stop sharing my/the patient's information. I know I cannot withdraw information that PAM had shared before I told PAM to stop. PAM may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to PAM telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to PAM telling them to revoke this form. **Cost for medical records is \$15 per patient, with a maximum family cost of \$30 (2+ patients)**

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

Patient's Name

Parent/Legal Guardian's Name (if applicable)

Relationship to Patient

Signature of parent/Legal Guardian/Self (if 13+)

Today's Date

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

Reason For Release (Optional):

In an effort to better serve our patients, it is important for us to understand the reason that you/the patient is asking for their medical record or leaving our practice. Please choose the reason, for leaving, below.

- ☐ Sharing with outside provider for treatment purposes
- ☐ Transfer to an Adult Provider
- ☐ Moving away to (City) _____ State _____
- ☐ Insurance Change
 - ☐ Provider(s) not in new network
(New Network Name) _____
 - ☐ Tiering/Higher Co-pay/Higher Deductible Cost
- ☐ Other – Please Describe: _____

Important Notice:

You do NOT have to give permission to share these records. Pediatric Associates of Medford (PAM) 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.