Spy Pond Pediatrics

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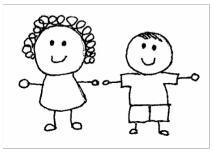

Authorization for Disclosure of Protected Health Information

This signed authorization form is required any time you wish deliver medical records directly to a third party. It is also required in order to request a full set of medical records when leaving our practice.

_____	_____	_____
Patient Last Name	Patient First Name	Patient DOB

REASON FOR DISCLOSURE:

☐ Transferring care to another provider ☐ Other: _____

INFORMATION TO BE DISCLOSED:

☐ Full medical record (see next page) ☐ Other: _____

DELIVERY METHOD (choose one):

☐ **MAIL TO** Name : _____

Address: _____

_____

☐ **PICK UP RECORDS** **OK to give to parent?** ☐

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/or social services communications; history of sexually transmitted or other communicable disease(s); results of tests for HIV/AIDS.

Please initial below all parts you agree to have shared.
By putting my initials by each item below I give permission for Spy Pond Pediatrics to share this type of information. I understand that if I do not initial the box, Spy Pond 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) Specify 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** Please list:

I understand that I can revoke this authorization form at any time, by sending a written letter to Spy Pond Pediatrics that asks them to stop sharing my/the patient's information. I understand that I cannot withdraw any information that Spy Pond Pediatrics has already shared before I asked them to stop. This approval will end in 12 months, or sooner if I send a written letter.

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

_____ _____

Signature: Self (if 13+)/Parent /Legal Guardian Date

_____ _____

Printed Name Relationship to Patient (if not self)

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