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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFOMATRION

Patient name: _____

Date of Birth: _____ **Phone number:** _____

Address: _____

_____

REASON FOR RELEASE OF RECORDS: _____

I GIVE PERMISSION FOR MILTON PEDIATRIC TO RELEASE MY HEALTH INFORMATION TO:

Name: _____

Address: _____

_____

RELEASE THIS INFORMATION VIA:

☐ Partners Patient Gateway

☐ Secure email *****please note, emails sent from Milton Pediatric are secure. We have no knowledge of any recipient's security status***** (provide email below)

Email address _____

☐ Fax/under 20 pages (provide number) _____

☐ Regular mail (USPS) (provide address below) ****Please note copying & postage fees will apply for records not mailed to medical facilities*****

_____

_____

INFORMATION TO BE RELEASED:

☐ Medical Records Abstract, e.g. history & physical, office notes, immunizations, operative/procedure reports, consults, lab & test results, discharge summary. Please check box below:
☐ 2 years ☐ 5 years

☐ Other (please specify and include dates)

_____

_____

RELEASE OF PRIVILEGED OR PROTECTED HEALTH INFORMATION: PLEASE CHECK THE BOX TO INDICATE YOU GIVE PERMISSION TO RELEASE THE FOLLOWING INFORMATION:

☐ Sexually Transmitted Diseases
☐ Domestic Violence Victim's Counseling
☐ Sexual Assault Victim's Counseling
☐ Information about Family Planning Services
☐ Information relating to confidential communications with a psychotherapist, psychologist, social worker, allied mental health professional or human service professional
☐ Alcohol and/or Drug Abuse or Test results (protected by Federal Confidentiality Rules 42CFR Part 2 – Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part2)
☐ HIV/AIDS diagnosis/treatment
☐ Genetic Testing
☐ Abortion consent Form(s)
☐ Mammography records

I UNDERSTAND AND AGREE THAT:

Milton Pediatric cannot control how the recipient uses or shares the information released, and that laws protecting its confidentiality at Milton Pediatric may not protect this information once it has been released to the recipient.

This authorization is voluntary. I understand that I may refuse to sign, or may revoke this authorization for any reason, and that such refusal will not affect the treatment I receive from Milton Pediatric.

I may cancel this authorization at any time by submitting a written request to Milton Pediatric, except: a) to the extent this release has already been acted upon; b) if I signed this authorization as a condition of obtaining insurance, other laws may provide the insurer with a right to contest a claim under the policy.

That this Authorization will automatically expire 1 year from the date signed, unless otherwise specified.

_____ _____
Patient Signature Date:

If Patient is a minor or is incapacitated, physically or mentally, provide the following signature:

_____ _____
Signature of Parent/Guardian/Personal Representative Date:

_____
Relation to Patient