MILTON PEDIATRIC ASSOCIATES, LLC.

340 Wood Road Suite 301 Braintree, MA 02184 P: 781-356-6200 F: 781-356-6299	10 Hawthorne Place Suite 110 Boston, Ma 02114 P: 857-557-6100 F: 781-701-3298

AUTHORIZATION TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION
MENTAL HEALTH PROVIDER NOTES

Patient Name: _____
Last First Middle

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

Date of Birth: _____

SPECIFY MENTAL HEALTH PROVIDER NOTES TO BE DISCLOSED:

(e.g., all mental health provider notes, mental health provider notes between certain dates of treatment)

_____

RECIPIENT:

Name of person or class of persons to whom the Practice may disclose my mental health provider's notes:

_____.

Address of the recipient or where my mental health provider's notes should be delivered:

_____.

TERM:

This Authorization will remain in effect *(please check one of the following)*:

☐ From the date of this Authorization until the _____ day of _____, 20___.

☐ Until the following event occurs: _____.

☐ Other: _____.

PURPOSE OF RELEASE:

By my signature below, I hereby authorize the Practice to use and/or disclose to the Recipient my mental health provider's notes for the term of this Authorization for the following specific purpose(s):
("at the request of the patient" is sufficient if the patient is initiating this Authorization)

_____

_____.

ACKNOWLEDGMENTS:

- I understand that I am responsible for paying the fee that the Practice charges for the copy of the mental health provider's notes that I have requested, whether I have authorized the Practice to release such mental health provider's notes to me or to another Recipient identified above.
    - $10 for a hard copy of mental health provider notes that is maintained by the Practice in hard copy
    - up to $6.50 for an electronic copy of mental health provider notes that is maintained by the Practice electronically
    - free of charge for MassHealth patients
- I understand that once the Practice discloses my mental health provider's notes to the Recipient, the Practice cannot guarantee that the Recipient will not re-disclose my mental health provider's notes to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my mental health provider's notes.
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of the Practice's treatment of me; except, however, if my treatment by the Practice is for the sole purpose of creating mental health provider notes for disclosure to the Recipient identified in this Authorization, in which case the Practice may refuse to treat me if I do not sign this Authorization.
- I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to the Practice at the address listed above. The revocation will be effective immediately upon the Practice's receipt of my written notice, except that the revocation will not have any effect on any action taken by the Practice in reliance on this Authorization before it received my written notice of revocation.
- I may contact the Practice by mail and/or telephone at the address and phone number listed above.
- I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my mental health provider's notes. By my signature below, I hereby, knowingly and voluntarily, authorize the Practice to use and/or disclose my mental health provider's notes in the manner described above.

_____ _____

Signature of Patient Date

If the patient is a minor or is incapacitated (physically or mentally), provide the following signature:

_____ _____

Signature of Parent/Guardian/Personal Representative Date

_____

Description of Relationship to Patient