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 FOR TWO-WAY EXCHANGE OF INFORMATION

Patient Name: _____
Last First Middle

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

Date of Birth: _____

By my signature below, I authorize each of the following individuals to disclose my health information to the other and to communicate with each other about me in accordance with this Authorization form.

Name: _____
Address: Milton Pediatric Associates
340 Wood Road, Suite 301
Braintree, MA 02184
Phone: _____

Name: _____
Address: _____
_____
_____
Phone: _____

SPECIFY INFORMATION TO BE DISCLOSED:

INFORMATION TO BE RELEASED: Medical Records Abstract, e.g. history & physicals, immunizations, operative/procedure reports, consults, lab & test results, discharge summary.

Please check box below:

☐ 2 years ☐ 5 years ☐ Other (please specify and include specific dates) _____

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 TWO-WAY EXCHANGE OF INFORMATION:

I authorize the two-way exchange of information for the following purpose(s) *(e.g., treatment, care coordination, payment of care, etc.; "at the request of the patient" is sufficient if the patient is initiating this Authorization)*:

_____
_____.

ACKNOWLEDGMENTS:

- I understand that once my health information has been disclosed, there is no guarantee that the recipient will not re-disclose my health information 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 health information. Notwithstanding the foregoing, I understand that the individuals identified above are required to maintain the privacy and confidentiality of my health information, and will re-disclose such information, if at all, only in accordance with applicable law.
- 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 my treatment by my provider; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient, in which case my provider 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 each of my providers. The revocation will be effective immediately upon each provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by the applicable provider in reliance on this Authorization before it received my written notice of revocation.
- I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the two-way exchange of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize the two-way exchange of my health information 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

***** Please complete the following page regarding Highly Confidential Information. *****

MY HIGHLY CONFIDENTIAL INFORMATION:

By signing below, I specifically authorize the two-way exchange of the following types of highly confidential information, if any such information will be disclosed pursuant to this Authorization:

• information about HIV/AIDS status • information about genetic testing • information about treatment of substance abuse (alcohol or drug)* • information about research involving controlled substances	• information about venereal disease(s) • information about family planning services • abortion consent form(s) • mammography records • mental health information • notes prepared by a mental health provider	• if I am an emancipated minor, information about my treatment and diagnosis for which I have consented as an emancipated minor (except that this information shall not be disclosed to my parents)

I have struck any and all information listed above that I do not want to be exchanged.

_____ _____

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

** Notice to recipient of Substance Use Disorder information: This record which has been disclosed to you is protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this record unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed in this record or, is otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.*