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

REQUEST FOR PROTECTED HEALTH INFORMATION
To OR From Milton Pediatric Associates, LLC

Reason for Request: ☐ **Transfer Care** ☐ **Other (please Specify**_____

IF MPA is requesting Medical Records:
*Milton Pediatric Associates, LLC (the Practice) hereby requests health information from*_____
in accordance with this HIPAA-compliant Authorization signed by the patient. *(the Provider)*

Patient Name: _____
Last First Middle

Date of Birth: ____/____/_____

Home Address: _____ Home Phone: _____

_____ Cell Phone: _____

City, State/Zip Code _____

INFORMATION REQUESTED:

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 specific dates)** _____

Address of the recipient or where health information should be delivered:

Practice Name:_____

PCP:_____

Address:_____

City:_____ **State**_____ **Zip code**_____

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 Provider to disclose to the Practice my health information 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 once the Provider discloses my health information to the Practice, the Provider cannot guarantee that the Practice 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 Practice is 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 the Provider's treatment of me; except, however, if my treatment by the Provider is for the sole purpose of creating health information for disclosure to the Practice, in which case the 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 the Provider. The revocation will be effective immediately upon the Provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by the 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 disclosure of my health information by the Provider to the Practice. By my signature below, I hereby, knowingly and voluntarily, authorize the Provider to disclose 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 disclosure 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 the Provider to disclose to the Practice.

_____ _____

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