Longwood PEDIATRICS, LLP
Preferred location. Preferred care.
319 Longwood Avenue | Boston, Massachusetts | 617.277.7320

Authorization for Disclosure of Protected Health Information

If the patient is less than 18 years of age, this form must be completed by a parent or legal guardian
If the patient is 13-17 years of age, a separate Consent for Release of Sensitive Information must be completed **by the patient**
If the patient is 18 years of age or older, this form must be completed by the patient

Please be aware that we may require up to three weeks to processes any and all medical record requests

Patient Information

Patient First Name	Patient Last Name	Patient Date of Birth

Reason for Disclosure

Please note that the **first copy of medical records is free** if you are transferring care to another provider. Additional copies (or copies for other reasons) are charged at $0.72 per page for the first 100 pages, and $0.37 for each additional page.

□ Transferring Care to a different provider. **Your account will be inactivated**. Effective Date of Transfer:_____

□ Other. **Your account will stay active**. Please specify:_____

Information to be Disclosed to

Complete medical records will be mailed via USPS. They will **NOT** be faxed or emailed. This may be your home address or your provider's address.

Name

Street Address

City/Town State Zip code

Information to be Disclosed

☐ Entire Medical Record

☐ Record covering the following dates only: From_____ to_____

☐Other: Please specify:_____

Re-Release of Information

☐ I authorize Longwood Pediatrics, LLP to re-release records from other physicians or facilities that may be included in the medical record (example: letters from consultants)

Disclosure of Sensitive Information

HIV/AIDS Testing or Treatment	□ Y	□ N	Social Work Notes	□ Y	□ N
Pregnancy/Sexual Health	□ Y	□ N	Mental/Behavioral Health Information	□ Y	□ N
Substance Use/Abuse	□ Y	□ N			

Signature

I authorize Longwood Pediatrics, LLP to release all medical information as requested above. Information will not be release without a valid signature. I understand that I may revoke this authorization by submitting written notice of revocation to Longwood Pediatrics, LLP. This Authorization will automatically expire 90 days from the signature date.

If Patient is 18 or older: _____ Patient Signature _____ Date

If Patient is Under 18: _____ Relation to Patient _____ Signature of Parent/Guardian _____ Date