Longwood Pediatrics
ATTN Medical Records
319 Longwood Ave
Boston, MA 02115
Fax: 617-277-7834

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, the **patient** must sign and date the "Disclosure of Sensitive Information" section to authorize release this information **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	Patient's PCP

Excessive requests for medical records may request in a fee of $0.72 per page for the first 100 pages and $0.34 per page for each additional page

How would you like to receive your records? (Please choose one):

□ CD □ USB □ Fax Number:_____

Unfortunately, we are unable to email records at this time

Reason for Disclosure

□ Transferring care to another provider. **Your account will be inactivated.** Date and reason for transfer:_____

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

Information to be Disclosed to

Complete medical records will be mailed via USPS or faxed. They will **NOT** be 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			

Patient Signature (if 13 or over) | Date

Signature

I authorize Longwood Pediatrics, LLP to release all medical information as requested above. Information will not be released 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 365 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