Longwood Pediatrics, LLP
319 Longwood Ave, Boston, MA 02115

Authorization for Release of Information

I hereby authorize Longwood Pediatrics, LLP to use or disclose my individually identifiable health information as described below:

Patient Name_____Date of Birth_____

Please identify those persons/organizations authorized to receive your information:

Please provide a specific description of your information to be used or disclosed (including dates):

Please provide a statement describing each purpose for the requested use or disclosure of your information:

Please read and initial the following statements:

- I understand that Longwood Pediatrics, LLP will not condition my treatment (and, if applicable, payment for my health care, my enrollment in a health plan, or eligibility for benefits) on whether I provide authorization for the requested use or disclosure – except in limited circumstances (e.g. if treatment is necessary for the purpose of certain protected health information for disclosure to third party, such as physical exams for school, camp and employment purposes).

  Initials: _____

- I understand that I may revoke this authorization at any time by notifying Longwood Pediatrics, LLP in writing; however, such revocation does not affect any actions taken by Longwood Pediatrics, LLP before Longwood Pediatrics received my written revocation.

  Initials: _____

(OVER)

- I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

  Initials: _____

- I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

  Initials: _____

- I understand this authorization will expire on

  _____ or _____
  Identify Date (Month, Day, Year) Identify Expiration Event

  Initials: _____

- I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization.

  Initials: _____

_____

Signature of Patient, Parent, Legal Guardian or Personal Representative of Individual (Note: Form must be completed before signing)

Date_____

Printed Name_____

Relationship to patient if not patient_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION