Longwood Pediatrics, LLP
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Boston, Massachusetts 02115
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For office use only

Date received _____ Initials _____
Date records mailed _____ Initials _____
Date inactivated _____ Initials _____

Authorization for Disclosure of Protected Health Information

If patient is ≥18 years of age, form must be completed and signed by patient; if patient is <18 years of age, form must be completed and signed by parent/guardian
For patients 13-17 years old, separate Consent for Release of Sensitive Information must be completed by the adolescent

PATIENT INFORMATION

_____ _____ _____
Patient Last Name Patient First Name Patient DOB

REASON FOR DISCLOSURE

REASON FOR DISCLOSURE (please note, there is no charge for 1 copy of the medical record if you are transferring care to another provider, but there is a charge of 72¢/page for the 1st 100 pages and 37¢ for each additional page for other reasons or additional copies)

❑ Transferring care to other provider (Effective date of transfer _____)

❑ Other: Please specify reason _____

INFORMATION TO BE DISCLOSED

❑ Entire medical record (please note, we do not release records to 3rd parties but only to patients or parents/guardians)

❑ Record covering the following dates only: From_____To_____

❑ Other, specify details_____ .

INFORMATION TO BE DISCLOSED TO:

_____ _____
Name Telephone

_____
Address

_____
Email

DISCLOSURE OF SENSITIVE INFORMATION

Certain types of sensitive information require specific authorization to be released. Please indicate below if you would like the following types of information to be included in the release. **A check indicates you DO want to include the information**. Not checking the box indicates you DO NOT want to include the information.

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

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).

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 90 days from the date of signature.

If patient is ≥18 years of age: _____ _____
Patient Signature Date

If patient is <18 years of age: _____ _____
Parent/Guardian Signature Date