Longwood Pediatrics, LLP
319 Longwood Avenue
Boston, Massachusetts 02115
Tel: 617-277-7320 Fax: 617-277-7834

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

(please note: the **first copy of your medical record is free** if you are transferring care to another provider; additional copies (or copies for other reasons) are charged at 72¢/page for the 1st 100 pages, and 37¢ for each additional page.)

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

☐ Other: Please specify reason _____

INFORMATION TO BE DISCLOSED

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

☐ 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 (Y = yes; N = no).

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			

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

UPDATE OF INSURANCE

Please be sure to update your insurance with your new Primary Care Physician's information.
Longwood Pediatrics wishes you all the best and a future of good health.