Allergy West

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____
Address: _____ Phone: _____

I hereby authorize Pediatrics West, PC, and its clinicians and employees to use, disclose to or obtain from the individual or organization named below the specified protected health information.

Records *Released* To:	**Records *Obtained* From:**
Name of Practice:	Name of Practice:
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Fax:	Fax:

Purpose of request:

New Patient ☐ Legal ☐ Transferring Out of Practice: Moved ☐
Medical Care ☐ Personal ☐
Other: _____

Information to be released or obtained:

All Records ☐
Partial Records ☐ Treatment Dates: _____

History/Physical ☐ X-rays ☐
Immunizations ☐ Labs ☐ Other: _____

Format: Records are released in electronic format (CD)

The section below MUST be completed for ALL patients.

In compliance with Massachusetts Statutes, which require specific authorization to release otherwise privileged information, the following information WILL BE RELEASED unless indicated by my initials.

____ Blood/alcohol test results

____ Substance Abuse (drug/alcohol) diagnosis, treatment, or referral information (federal regulations require a description of how much and what kind of information is to be disclosed). Describe: _____

____ Information related to sexually transmitted disease(s)

____ Genetic testing information and/or records

____ Communications between me, any psychiatrist, psychologist, psychotherapist or other behavior health professional

____ Other mental health information, communications and/or records

____ HIV, AIDS or ARC information and/or records

____ Abortion consents/records or family planning services

____ Sexual Assault or domestic violence treatment

____ Mammography records

____ Information regarding treatment and diagnosis, if I am an emancipated minor (except to my parents)

____ Information acquired by any social worker consulting me in a professional capacity

Patient Name: _____

Patient*/Representative Signature: _____ **Date:** _____

Print Name & Relationship if other than Patient: _____

I understand that state and federal law protecting health information privacy may no longer protect the information furnished once it has been released. I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by Pediatrics West before Pediatrics West received written notice of revocation. I further understand that I must provide any notice of revocation in writing to the **Medical Record Department, Pediatrics West, 133 Littleton Road, Westford, MA 01886.**

I understand that I may refuse to sign this Authorization and that such refusal or revocation will not affect the commencement, continuation, or quality of Pediatrics West's treatment of me; except, however, if my treatment at Pediatrics West is for the sole purpose of creating medical information for disclosure to the recipient identified in this Authorization. In that case, Pediatrics West may refuse to treat me if I do not sign this Authorization. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations or other applicable state or federal laws. I understand that if information is requested by my health insurer and I refuse to sign a required authorization, the health insurer may in certain instances deny me payment, enrollment or eligibility for benefits. I understand that I may inspect or request copies of any information disclosed by this authorization.

I hereby release Pediatrics West, its professionals, employees and agents from all liability arising from this authorized disclosure of my health information. Unless otherwise revoked, this Authorization will remain in effect from the date of this Authorization until the following date _____ or if no date is inserted than within one year

I understand there is a fee for the reproduction of the requested health information. The fee charged, as allowed by applicable Massachusetts law, may vary depending on the number of pages to be copied.

Date: _____ Signature of Patient* or Representative: _____

Print Name & Relationship if other than Patient: _____

***Patients 18 years or older must sign for self*.**

Amount Paid: _____

Employee Initials: _____