Allergy West
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AUTHORIZATION TO USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Patient Name: _____ **DOB:** _____

Street Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip** _____

I hereby authorize the release of my medical information to the individual/organization named below. Enter where you would like information released to, and to whom you would like the information obtained from.

Records Released To:
Name of Practice:_____
Street Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Records Obtained From:
Name of Practice: _____
Street Address: _____
City/State/Zip: _____
Phone: _____
Fax: _____

Treatment Dates: _____
Purpose of Request: _____
Information Requested: _____

Format: Records are released in electronic format (CD)

Initial below if you do not want the following items, which may appear in your records, to be authorized for use and/or disclosure.

_____ HIV/AIDS related information and/or records
_____ Psychotherapy notes
_____ Other mental health information, communications and/or records
_____ Information acquired by any social worker consulting me in their professional capacity
_____ Contain communications between myself and any psychotherapist, psychologist or allied mental health professional
_____ Contain any treatment notes, communications or other information regarding domestic violence or sexual assault
_____ Genetic testing information and/or records
_____ Contain any blood alcohol test results
_____ Relate to venereal disease
_____ Regard a child born out of wedlock
_____ 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: _____

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to the **Medical Record Department, Allergy West, 133 Littleton Road, Suite 103, Westford, MA 01886**. 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 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 may be re-disclosed and no longer protected by federal or state privacy laws or regulations.

I further understand that authorizing the disclosure of this health information is voluntary. 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. If information is requested by my health insurer and I refuse to sign a required authorization, I understand that the health insurer may in certain circumstances deny payment, enrollment or eligibility for benefits. I understand that I may inspect or request copies of any information disclosed by this authorization as allowed by law.

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**.**

Signature of Patient or Representative: _____ Date _____

Print Name & Relationship if other than Patient: _____
**Patients 18 years or older must sign for self.*

Amount Paid: _____
Employee Initials: _____