AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I hereby authorize HD Pediatrics to use and/or disclose the following protected health information from the medical records of the patient listed below. I understand that once HD Pediatrics discloses my health information to the recipient, HD Pediatrics cannot guarantee that the recipient will not re-disclose my health information to a third party. Any third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

PATIENT NAME:_____ **DATE OF BIRTH**:_____

ADDRESS:_____

PHONE NUMBER:_____ **EMAIL**:_____

RELEASE TO (Who do you want to receive the records):

NAME: _____

FAX OR EMAIL: _____

ADDRESS: _____

RELEASE FROM (Who has the records now):

_____

_____

_____

TREATMENT DATES: From _____ To: _____

Please indicate the specific information to be released:
( ) Complete medical record
( ) Other: _____

HIGHLY CONFIDENTIAL INFORMATION

By signing below, I specifically authorize the use and/or disclosure of the following types of highly confidential information, if any such information will be used or disclosed pursuant to this Authorization:

- **HIV/AIDS Testing, Results or Treatment • Treatment/Diagnosis of Substance Abuse (alcohol or drug) • Mental Health Communications • Rape/Sexual Abuse**
- **Psychotherapy Notes • Sexually Transmitted Disease**
- **Social Worker Communication • Genetic Testing**
- **Developmental Disability**
- **Child/Elder/Disabled Abuse & Neglect**
- **If I am an emancipated minor, information about treatment and diagnosis (except to my parents)**

X _____ _____

Signature of Patient or Legal Representative **Date**

PURPOSE OF DISCLOSURE:

( ) Personal copy (charges apply) ( ) Medical Care ( ) Legal ( ) Insurance ( ) Other _____

IMPORTANT: PLEASE SIGN AUTHORIZATION FORM ON PAGE 2

REVOCATION: I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment at HD Pediatrics; except, however, if my treatment at HD Pediatrics is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization in which case HD Pediatrics may refuse to treatment if I do not sign this Authorization.

TERM: I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to HD Pediatrics at the address listed below. The revocation will be effective immediately upon HD Pediatrics receipt of my written notice, except that the revocation will not have any effect on any action taken by HD Pediatrics in reliance on this Authorization before it received my written notice of revocation.

( ) From the date of this Authorization until the _____ day of _____ 20__

( ) Until the following event occurs: _____

( ) Other _____

I understand that I have the right to request access to, view, or have copied my protected health information upon completion of this Authorization. I understand that HD Pediatrics may charge a reasonable cost-based fee associated with copying my Protected Health Information. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information.

_____	_____	_____
Signature of Patient/Legal Representative	**Printed Name of Patient/Legal Representative**	**Date**

THIS AUTHORIZATION SHALL BE DEEMED INVALID UNLESS ALL ENTRIES ARE COMPLETED AND THE FORM IS SIGNED ON PAGE 2

PLEASE FORWARD ALL MEDICAL RECORDS TO: MEDICALRECORDS@HDPEDI.COM OR FAX: 781-886-3010 OR MAIL: 1524 TURNPIKE ST, BOX 1, STOUGHTON, MA 02072