Pediatric Associates of Wellesley, Inc.

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

By signing this authorization, I hereby authorize Pediatric Associates of Wellesley ("PAW"), to release health information including any and all copies of medical records of:

Patient Name (s):_____ Date of Birth _____
_____ _____
_____ _____

To assure privacy and confidentiality it is recommended that records be picked up.

Contact information for person picking up records:
Name:_____Relationship:_____
Address:_____
Phone:_____

Contact information for new provider (records can be mailed for a fee):
Name:_____
Address:_____
Phone:_____Fax:_____

Contact information for specialist or other recipient (records can be mailed for a fee):
Name:_____
Address:_____
Phone:_____Fax:_____

For the Purpose(s) (*Check the appropriate box(s) and include short description(s))*

- ❑ Transferring out of Practice:
  - ❑ Relocation
  - ❑ New Insurance
  - ❑ Age
  - ❑ Other

    _____
    Please be Specific
- ❑ Medical Care/ Specialist Referral: _____
- ❑ Legal Matter:_____
- ❑ Insurance:_____
- ❑ Personal Use:_____
- ❑ Other *(please specify)* _____

INFORMATION TO BE RELEASED (Please check all that apply and specify dates):

- ❑ Complete Medical Record (complete next section)
- ❑ Medical Record for Specific Dates of Service _____
- ❑ Lab Results/Radiology Reports _____
- ❑ Billing Information _____
- ❑ Other (specify) _____

I request the release of the specifically protected or privileged categories of information below.
This information will <u>not</u> be released <u>unless</u> I initial the appropriate category(s)
Patient authorization required for each release request

___ HIV test results Specify date(s) _____
___ Alcohol and Drug Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2
___ Psychotherapy notes recorded by a mental health professional documenting or analyzing the contents of conversation(s) during private, joint, group or family counseling session(s) and that are separate from the medical record.
___ Other records of professional services by licensed psychologists or Social Workers
___ Domestic Violence and/or Sexual Assault Victims' Counseling
___ Child Abuse, DSS and/or DYS documents and records
___ Educational testing and reports
___ Information relating to AIDS or sexually transmitted diseases (testing, treatment, etc.)

I understand and agree that I am financially responsible for the following fees associated with my request: copying charge, including the cost of supplies, labor, and postage related to the production of my information. I understand that the charge for this service is a minimum charge of $5.00 per patient. I also understand that processing fees are payable in full before my medical information is released.

I understand that this authorization is voluntary; however, my medical information will not be released without it. This authorization will continue in force for ninety (90) days from the date of signing unless I otherwise revoke it in writing prior to that time. My medical treatment by PAW will not be effected whether or not I provide this authorization. I also understand that any health information disclosed by this release may be subject to re-disclosure by the recipient and may no longer be protected by any applicable privacy regulations.

Signature of Patient or Legal
Guardian/Representative:_____

Print Name:_____Date:_____

Relationship To Patient: _____

Best Phone Contact Number:_____

For Office Use:

Date Received: _____

Date Ready for Pick up: _____

Patient /Guardian Notified: _____

Completed by: _____

Payment Status: _____