Pediatric Associates of Wellesley, Inc

PERMISSION FORM
RELEASE OF MEDICAL INFORMATION

IN EFFECT FOR ONE YEAR OR LESS

(For Patient's Family Member, Care-Taker, or Other Patient/Parent Designated Person)

TODAY'S DATE ______________________

PATIENT NAME IS: _____________________________________DATE OF BIRTH _____________

PERMISSION IS GIVEN FOR:

____
PRINT FULL NAME RELATIONSHIP

And/Or ____
PRINT FULL NAME RELATIONSHIP

_____ 1. TO ONLY DISCUSS RESULTS OF ANY APPOINTMENT TO WHICH THE ABOVE PERSON BRINGS THE PATIENT.

_____ 2. TO DISCUSS AND HAVE ACCESS TO THE HEALTH INFORMATION THAT IS FOUND IN MY CHILD'S *PEDIATRIC ASSOCIATES'* MEDICAL RECORD.

INCLUDING ALL OF PATIENT'S information (exchanged verbally or in writing) regarding my health and medical care from the following personnel: (check all that apply)

___Physicians/Providers ___Nurses ___Medical Records Staff

___Billing Staff ___Administration

With the EXCEPTION of ANY of the following:

INITIAL ANY THAT YOU DO **NOT** WANT RELEASED TO PERSON LISTED ABOVE

____ HIV diagnosis, test results, treatment Specify date(s) ________________________
____ Information relating sexually transmitted diseases (testing, treatment, etc.)
____ 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)
____ 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
____ OTHER (PLEASE SPECIFY) ____
____

THIS AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE YEAR FROM DATE OF FORM.

UNLESS: _____I REVOKE it in WRITING OR: ____ STOPS on this date: __________________

XX____
SIGNATURE OF PARENT or GUARDIAN DATE

BEST CONTACT PHONE # ____

PAW FILE