Medical Records Release Authorization

Alena Ashenberg MD, Pediatrics
Boston Children's
Primary Care Alliance

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Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Phone: _____

Address: _____

City: _____ State:_____

Zip:_____

Authorization

NOTE: All references below to "patient" are for the patient listed above.

I give my permission for Alena Ashenberg MD, Pediatrics to share my/the patient's medical record with the person or organization listed below. My/the patient's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

Choose one:

❍ Complete Medical Record (except confidential information defined by Massachusetts law)

❍ Medical Record for the time
from: _____ to: _____

❍ Only information from a certain illness or injury. Please describe:

_____

_____

_____

❍ Specific Information:

_____

_____

Send a copy of my/the patient's medical records to:

Name: _____

Organization: _____

Address: _____

City: _____ State:_____

Zip:_____

Phone: _____

Fax: _____

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (sexually transmitted) or other communicable disease(s)
- Results of tests for HIV/AIDS

Please initial all parts you AGREE to have shared.

By putting my initials by each item below I give permission for Alena Ashenberg MD, Pediatrics to share this type of information. I understand that if I do not initial the box, Alena Ashenberg MD, Pediatrics will NOT share this information about me/the patient's health to the person or organization listed above.

HIV test results (Specific approval required for each release request)

Specify dates: _____

Initial: _____

Genetic screening test results

Specify type of test: _____

Initial: _____

Alcohol and drug abuse treatment records
Protected by Federal Confidentiality Rules 42 CFR Part 2. Federal rules prohibit any further disclosure of this information unless further disclosures is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.

Initial: _____

Details of mental health diagnosis and/or treatment provided by a psychiatrist, psychologist, mental health clinical nurse specialist, or licensed mental health clinician (LMHC)
I understand that my permission may not be required to release my mental health records for payment purposes.

Initial: _____

Confidential communications with a licensed social worker

Initial: _____

Information related to the use of alcohol, drugs, and/or tobacco

Initial: _____

NEXT PAGE >

Information related to a sexually transmitted disease, sexual activity and/or orientation

Initial: _____

Information related to diagnosis or treatment of pregnancy

Initial: _____

Information related to child abuse or neglect

Initial: _____

Information concerning family violence and/or domestic violence victims' counseling

Initial: _____

Other(s): Please list: _____

_____

_____

Initial: _____

I know I can revoke this form at any time. I know I cannot withdraw information that Alena Ashenberg MD, Pediatrics had shared before I told Alena Ashenberg MD, Pediatrics to stop. If I no longer want my/the patient's medical record shared I will send a written letter to Alena Ashenberg MD, Pediatrics telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to Alena Ashenberg MD, Pediatrics telling them to revoke this form.

By signing below, I agree that I understand the above and voluntarily allow my/the patient's medical record to be shared.

Patient's name: _____

Parent/Legal guardian's name (if applicable):

_____

Relationship to patient:

_____

Signature of Parent /Legal Guardian /Self (if 13+):

_____

Date: _____

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Reason for release

In an effort to better serve our patients, it is important for us to understand the reason that you/the patient is asking for your medical record or leaving our practice. Please choose the reason below.

❏ Sharing with outside provider for treatment purposes

❏ Transfer to an adult provider

❏ Moving away to:

City: _____ State:_____

❏ Insurance change

❏ Provider(s) not in new network (network name):

_____

❏ Tiering / higher co-pay / higher deductible cost

❏ Other

Please describe: _____

_____

_____

Important notice

You do not have to give permission to share these records. Alena Ashenberg MD, Pediatrics will not base your/the patient's treatment on whether or not you sign this form.

After your/the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to get a copy of this signed form.