

# Pediatrics West<sup>PC</sup>

133 Littleton Road, Suite 101, Westford, MA 01886

Phone: 978-577-0437 • Fax: 978-692-9904

www.pediatricswest.com

## AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby authorize Pediatrics West, PC, and its clinicians and employees to use, disclose to or obtain from the individual or organization named below the specified protected health information.

### Records Released To:

### Records Obtained From:

Name of Practice:	Name of Practice:
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
Fax:	Fax:

### Purpose of request:

New Patient  Legal  Transferring Out of Practice: Age  Moved   
Medical Care  Personal  Other: \_\_\_\_\_

### Information to be released or obtained:

All Records   
Partial Records  Treatment Dates: \_\_\_\_\_

History/Physical  X-rays   
Immunizations  Labs  Other: \_\_\_\_\_

**Format: Records are released in electronic format (CD)**

#### Westford

133 Littleton Road, Ste. 101  
Westford, MA 01886

#### Groton

120 Boston Road, Ste. 1  
Groton, MA 01450

#### Fitchburg

19 Pierce Avenue, Ste. B  
Fitchburg, MA 01420

**The section below MUST be completed for ALL patients.**

**In compliance with Massachusetts Statutes, which require specific authorization to release otherwise privileged information, the following information WILL BE RELEASED unless indicated by my initials.**

- Blood/alcohol test results
- Substance Abuse (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: \_\_\_\_\_
- Information related to sexually transmitted disease(s)
- Genetic testing information and/or records
- Communications between me, any psychiatrist, psychologist, psychotherapist or other behavior health professional
- Other mental health information, communications and/or records
- HIV, AIDS or ARC information and/or records
- Abortion consents/records or family planning services
- Sexual Assault or domestic violence treatment
- Mammography records
- Information regarding treatment and diagnosis, if I am an emancipated minor (except to my parents)
- Information acquired by any social worker consulting me in a professional capacity

**Patient Name:** \_\_\_\_\_

**Patient\*/Representative Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name & Relationship if other than Patient:** \_\_\_\_\_

I understand that state and federal law protecting health information privacy may no longer protect the information furnished once it has been released. 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 further understand that I must provide any notice of revocation in writing to the **Medical Record Department, Pediatrics West, 133 Littleton Road, Westford, MA 01886.**

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. 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 described above may be re-disclosed and is no longer protected by these regulations or other applicable state or federal laws. I understand that if information is requested by my health insurer and I refuse to sign a required authorization, the health insurer may in certain instances deny me payment, enrollment or eligibility for benefits. I understand that I may inspect or request copies of any information disclosed by this authorization.

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.**

Date: \_\_\_\_\_ Signature of Patient\* or Representative: \_\_\_\_\_

Print Name & Relationship if other than Patient: \_\_\_\_\_

**\*Patients 18 years or older must sign for self.**

**Amount Paid:** \_\_\_\_\_

**Employee Initials:** \_\_\_\_\_