Bass River Pediatric Associates

237 Station Avenue ● South Yarmouth, MA 02664 ● FAX 508 760-1919 ●

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: D.O.B.

Home Street Address _____ Apt#_____

City _____ State _____Zip code _____

Telephone HOME: ( ) _____MOBILE: ( ) _____

☐ I request a copy or authorize Bass River Pediatric Associates to release my/my child's protected Health Information including medical records to the following person(s) at the address/facility listed below:

☐ I authorize other facilities to release records to Bass River Pediatric Associates

Name/Facility

_____

Attention Telephone

_____

Address Fax

_____

City/State Zip

_____

PURPOSE OF RELEASE (check appropriate box below)

☐ Medical Care
☐ School
☐ Transfer of Care
☐ Legal
☐ Adolescent/Adult release to the Parent

INFORMATION TO BE RELEASED: DATE RANGE: _____
☐ Entire Medical Record
☐ Immunizations
☐ X-rays/reports
☐ Lab results
☐ Medical Record Abstract (e.g. History & Physical, Consults, Test results)
☐ Other (please specify):

(SEE BACKSIDE OF THIS DOCUMENT)

Authorization for release of Medical Records Information

Bass River Pediatric Associates has my permission to release/obtain information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child's medical record):

PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED

_____**HIV/AIDS Information (**Patient Authorization Required for Each Release Request)

_____**Genetic Screening Test Results** (Specify type of Test)

_____**Alcohol and Drug Abuse Treatment Records**
Federal rules prohibit any further disclosure of this information unless further disclosures are expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I can however cancel this authorization in writing at any time, except to the extent that Bass River Pediatrics has relied upon it.

_____**Details of Mental Health Diagnosis and /or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician.** I understand that my permission may not be required to release my mental health records for payment purposes.

_____**Confidential Communication with a Licensed Social Worker**

_____**Information related to a sexually transmitted disease**

_____**Information related to Diagnosis or treatment of Hepatitis**

_____**Information related to Diagnosis or treatment of Pregnancy**

_____**Information related to spouse abuse and/or child abuse or neglect**

_____**Information concerning family violence and/or Domestic Violence Victims' Counseling**

_____**Contain Information regarding rape and/or Sexual Assault Counseling**

_____**Other(s): Please List**

I hereby authorize Bass River Pediatrics (BRPA) to release/obtain any medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that BRPA cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at BRPA may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below. **This authorization will expire 1 year** from the signature date, unless otherwise specified. I can, however cancel this authorization in writing at any time, except to the extent that BRPA has relied upon it. For example, if I cancel it after BRPA has sent the requested records, BRPA will not retrieve those records. I understand the BRPA will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under 18 without emancipated status or a special condition.

Signature of Patient	**Name of Patient (Print)**	**Date**
Signature of Patient or Guardian	**Relationship to Patient**	**Date**