Woburn & North Andover Pediatric Associates
7 Alfred Street, Baldwin Park II, Woburn, MA 01801 - Phone 781-933-6236, Fax 781-938-8050
800 Turnpike Street, N. Andover, MA 01845 - Phone 978-557-5712, Fax 978-557-5406

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ Date of birth: _____

_____
Date that this authorization will expire. If no date stated, expires six months from the date signed.

I hereby authorize Woburn & North Andover Pediatric Associates to use and/or disclose the Protected Health Information as described below:

_____
Person or entity to whom information is being released

_____
Specify the reason that this information is being released – transfer of care, specialist appt, etc

_____
Identify specific information to be released & dates of care included

_____
Forwarding address or method of delivery – mail, pick up, etc

1. I understand that I may inspect or obtain a copy of the Protected Health Information described by this authorization.
2. I understand that the Practice named above will not condition treatment, payment or any other service to which I am otherwise entitled on my providing authorization for the requested use or disclosure of this information.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Practice's Privacy Officer. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
5. I understand that, in some circumstances, Massachusetts law may require that a minor's privacy be protected in regard to release of health information.
6. I understand that in requesting release of any medical records, including those from any previous healthcare provider, I hereby release Woburn Pediatric Associates & North Andover Pediatric Associates from any liability resulting from such release, and recognize that the Practice will not retain a copy of such records.
7. I understand that in keeping with the Practice's Notice of Privacy Practices, a reasonable charge is assessed for the cost of copying records that I request. Ordinarily, the **charge is $10 per record to a maximum of $20 per family**. In the case of oversized records, reasonable charges may be assessed per page, rather than as a flat fee.
8. The Practice will provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

Massachusetts state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature below, I authorize release, if so indicated, of the following medical information that may be held by the practice named above (Unless you check "yes", no such information will be released unless required for purposes not requiring your approval, e.g. treatment, or mandatory reporting of abuse cases to DSS):

Information pertaining to HIV status and records of care and treatment for HIV/AIDS:	Circle	YES	NO	N/A
Records of mental health care and treatment:	Circle	YES	NO	N/A
Records of care and treatment for sexually transmitted diseases:	Circle	YES	NO	N/A
Records of care and treatment for abuse:	Circle	YES	NO	N/A
Records of substance abuse care and treatment:	Circle	YES	NO	N/A

_____ _____
Signature of individual patient or representative Date signed

_____ _____
Print name of patient or representative Authority/relationship