Woburn & North Andover
pediatric associates & psychological services

Authorization for Use and Disclosure of Protected Health Information

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

I hereby authorize **Woburn and North Andover pediatrics** to use and/or disclose the Protected Health Information (hereafter PHI) as described below:

Person or entity to whom information is being released: _____

Reason this information is being released: **Transfer of Care**

Information to be released: **Last 5 years of record. Specify other** _____

PDF via Email (Free of charge): _____*Send release to **jconway@woburnpedi.com** which will confirm records will be sent to correct email

Paper copy to be picked up in office.

Please note: Payment must be made before the record is copied. $10 for the most recent five years and $20 for a complete copy of the medical record.

Date this authorization expires. If no date, expires 6 months from signed date: _____

1. I understand I may inspect or obtain a copy of the PHI described by this authorization.
2. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Practice. 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.
3. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and may not be subject to any law protecting its confidentiality.
4. I understand that, in some circumstances, Massachusetts law may require that a minor's privacy be protected regarding the release of health information.
5. I understand that in requesting release of any medical records, including those from any previous healthcare provider, I hereby release the Practice from any liability resulting from such release and recognize that the Practice will not retain a copy of such records.
6. The Practice will provide a copy of this signed authorization to you upon your request. This information will be disclosed to you from records which are confidentiality 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 PHI 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 (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 DCF):

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

_____

Signature of individual patient or representative Date signed

_____

Print name of patient or representative Authority/relationship