



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION
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Signed form may be faxed to:
617-730-0329, or mailed to:
HIM/Medical Records, Fegan B-014
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115

Please complete this form and sign on page 2 where indicated.

If you have questions related to this form, contact HIM/Medical Records at 617-355-7546

Demographics

Form with fields for Patient Last Name, First Name, MI, Home Street Address, Apt#, City, State, Zip, Children's MR#, Home Telephone, Date of Birth, and Alternate Telephone.

I authorize Boston Children's Hospital to release my/my child's protected health information including copies of my medical record of care to the following person(s) at the address/facility listed below:

Form with fields for Name/Facility, Attention, Telephone, Address Suite/Room, Fax, City/State, and Zip.

PURPOSE OF RELEASE (check the appropriate box below)

- Medical Care
School or Camp
Insurance*
Personal *
Legal Matter*
Other (please specify)

* Please refer to the Boston Children's Hospital Notice for information on copying fees that may be associated with this request. There may be additional charges for copies of photographs.

FORMAT OF RELEASE

- (please check the appropriate box below)
CD
Paper
Fax (to MD Office only)

INFORMATION REQUESTED

- Entire Medical Record (charges may apply)
DATE RANGE for information needed:
Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
Other - Specify information to be released:

SEE PAGE 2 ON REVERSE SIDE

Please complete both sides of this form and sign and date at the bottom of page 2

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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Boston Children’s Hospital has my permission to release 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	
Initial if info may be released	HIV test results (SPECIFIC PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) SPECIFY DATES:
Initial if info may be released	Genetic Screening Test Results (SPECIFY TYPE OF TEST)
Initial if info may be released	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 PART2. I can, however, cancel this authorization in writing at any time, except to the extent that Children’s has relied upon it.
Initial if info may be released	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 if info may be released	Confidential Communications with a Licensed Social Worker
Initial if info may be released	Information related to a sexually transmitted disease
Initial if info may be released	Information related to diagnosis or treatment of Hepatitis
Initial if info may be released	Information related to diagnosis or treatment of Pregnancy
Initial if info may be released	Information related to spouse abuse and/or child abuse or neglect
Initial if info may be released	Information concerning family violence and/or Domestic Violence Victims’ Counseling
Initial if info may be released	Contain information regarding rape and/or Sexual Assault Counseling
Initial if info may be released	Other(s): Please list

I hereby authorize Boston Children's Hospital (Children’s) to release 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 Children’s cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Children’s 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 90 days from the signature date, unless otherwise specified. I can, however, cancel this authorization in writing at any time, except to the extent that Children’s has relied upon it. For example, if I cancel it after Children’s has sent the requested records, Children’s will not retrieve those records. Instructions for canceling this authorization are included in the Boston Children's Hospital Notice of Privacy Practices.

I understand that Children’s 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 age 18 without emancipated status or a special condition.

_____	_____	_____
Signature of Patient	Name of Patient (please print)	Date
_____	_____	_____
Signature of Parent or Guardian	Relationship to Patient	Date