Washingtonville Pediatrics
Boston Children's Health Physicians
Until every child is well™

AUTHORIZATION
For the Release of
Medical Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Date of Birth: Mm dd yr	
Other identifier (social security number):	

I hereby authorize _____ [health care provider] to disclose or transfer my protected health information as indicated below.

This information is to be disclosed to:

Name:

Attention of:

Street Address:

City, State, Zip

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:
[ ] Transfer of health coverage [ ] Personal use [ ] Form completion [ ] Referral

[ ] Change in health care provider [ ] Other

This authorization expires in one year from the date signed or earlier _____
date

TO BE READ AND SIGNED BY PATIENT:
I understand the following:
a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
c. The disclosing provider will not condition treatment or payment based on my signing this authorization.
d. I am signing this authorization freely and under no pressure form any individual to do so.
e. The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
f. I acknowledge that I have had an opportunity to review this authorization and understand its intent and use.
g. I will receive a copy of this completed and signed authorization form.

There will be a charge of 75 cents per page for copying medical records plus cost of mailing.

Patient Signature:		Date:
Signature of Patient's Representative:	Relationship:	Date: