Children's Medical Office of North Andover
477 Andover Street
North Andover, MA 01845
978.975.3355
www.chmed.com

Authorization for the Release of Medical Records

Demographics

Patient Last Name _____ First Name _____ MI_____

Patient Date of Birth _____

Patient Address _____

Authorization

Note: All references below to 'patient' are for the patient listed above.

I give my permission for *Community Pediatrics of Andover to* share my/the patient's medical record with *Children's Medical Office of North Andover, PC.* My/the patient's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

Choose one:

- ☐ Medical Record (except confidential information defined by Massachusetts law)
- ☐ Medical Record for the time from _____to _____
- ☐ Only information from a certain illness or injury. Please Describe- _____

Please answer the following:

1.) Do you have an appointment scheduled with your new Primary Care Provider? ☐Yes ☐No
2.) If yes, what is the date? _____
3.) Would you like us to reach out to your new Primary Care Provider? ☐Yes ☐No

Electronically release my medical records to:

Children's Medical Office of North Andover, PC

477 Andover Street

North Andover, MA 01845

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (sexually transmitted) or other communicable disease(s) Results of tests for HIV/AIDS

Please initial all parts you agree to have shared.
By putting my initials by each item below I give permission for *Community Pediatrics of Andover* to share this type of information. I understand that if I do not initial the box, *Community Pediatrics of Andover* will not share this information about me/the patient's health to the person or organization listed above.

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Initial if info **may** be shared	**HIV test results** (Specific approval required for each release request) Specify Dates:
Initial if info **may** be shared	**Genetic Screening Test Results** (Specify type of test)
Initial if info **may** be shared	**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 Part 2.
Initial if info **may** be shared	**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 shared	**Confidential Communications with a Licensed Social Worker**
Initial if info **may** be shared	**Information related to the use of alcohol, drugs, and/or tobacco**
Initial if info **may** be shared	**Information related to a sexually transmitted disease, sexual activity and/or orientation**
Initial if info **may** be shared	**Information related to diagnosis or treatment of pregnancy**
Initial if info **may** be shared	**Information related to child abuse or neglect**
Initial if info **may** be shared	**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info **may** be shared	**Other(s): Please list**

I know I can revoke this form at any time. This means I can tell *Community Pediatrics of Andover to* stop sharing my/the patient's information. I know I cannot withdraw information that *Community Pediatrics of Andover* had shared before I told *Community Pediatrics of Andover* to stop. *Community Pediatrics of Andover* may already have shared it. If I no longer want my/the patient's medical record shared I will send a written letter to *Community Pediatrics of Andover* telling them to revoke this form.

This approval will end in 12 months or sooner if I send a written letter to *Community Pediatrics of Andover* telling them to revoke this form.

By signing below I agree that I understand the above and voluntarily allow my/the patient's medical record to be shared.

_____
Patient's Name

_____ _____
Parent/Legal Guardian's Name (if applicable) Relationship to Patient

_____ _____
Signature of Parent /Legal Guardian /Self (if 13+) Date