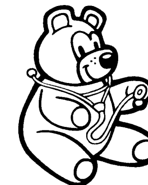
Authorization for Release of Protected Health Information FROM Bass River Pediatric Associates



Patient Name Last First Middle Initial	**Patient Date of Birth** (mm/dd/yyyy)
Patient Address Street City/Town State Zip Code	
Patient Phone Number	

I hereby authorize and request **Bass River Pediatric Associates** to release a copy of my medical records to:

____
Recipient's Name

____
Recipient's Address

____
Recipient's Phone Number Recipient's Fax Number

For the purpose of: ❑ Personal ❑ Legal ❑ Transferring Care ❑ Other

Requested Information:____ ❑ All Records

Covering the period from:____________________to ________________________

Protected under State Law: Please initial below	
Alcohol and/or Drug Abuse Treatment	I DO Authorize. Initial:
HIV/Communicable Disease*	I DO Authorize. Initial:
Genetic Testing	I DO Authorize. Initial:
Mental Health Services	I DO Authorize. Initial:
(Mental Health Services by a clinical nurse specialist, Psychologist, Social Worker, counseling professional or a physician specializing in psychiatry licensed under the provision of Title 32)	

*A separate release authorization is required for each request to release the results of HIV/AIDS testing, M.G. L. c111§ 70F

**Release of information must comply with the federal HIPAA Privacy Act and federal Confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, part 2 regulations. Note to recipient: This contains confidential information. 42 CFR part 2 prohibits you from making any further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse.

I hereby disclose my health information for the purposed noted above. I understand that once such information has been disclosed to the intended recipient, that BRPA cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. If I have questions about disclosure of my health information, I can contact Bass River Pediatric Associates Office Manager at 508-394-2116 ext. 100 or bassriverpediatrics@comcast.net

This authorization is valid for release of Protected Health Information for 180 days from date below **OR** (please indicate):

❑ a one-time disclosure ❑ upon termination from services ❑ until revoked in writing ❑ other

Patient or Legal Representative Name (print) ____

Address: ____

Patient or Legal Representative Signature:____________________________________Date: ____________

Relationship to Patient:________________________________Phone Number: ________________________

A facsimile or copy of this document is valid as the original.
Scan Completed Document to EMR: Consents and Contracts