Authorization for the Release of Psychotherapy Notes

Pediatric Associates of Malden
Boston Children's
Primary Care Alliance

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Important notice: Any release of psychotherapy notes MUST be approved by the Behavioral Health Provider. The Provider can choose to deny any request.

Demographics

Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

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

I give my permission for Chestnut Hill Pediatrics to share my/ the patient's psychotherapy notes with the person or organization listed below.

Choose one:

❍ All psychotherapy notes

❍ Psychotherapy notes for the period:

Date from: _____

Date to: _____

Share a copy of my/ the patient's psychotherapy notes with:

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Phone: _____ Fax: _____

Authorization

I know I can revoke this form at any time. This means I can tell Chestnut Hill Pediatrics to stop sharing my/ the patient's information. I know I cannot withdraw information that Chestnut Hill Pediatrics had shared before I told Chestnut Hill Pediatrics to stop since Chestnut Hill Pediatrics may already have shared it.

If I no longer want my/ the patient's medical record shared, I will send a written letter to Chestnut Hill Pediatrics telling them to revoke this form. This approval will end in 12 months or sooner if I send a written letter to Chestnut Hill Pediatrics telling them to revoke this form.

By signing below I agree that I understand the above. I am voluntarily allowing 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: _____

Patients under the age of 18 may be allowed to provide or decline release without parental consent under Massachusetts law.

Important notice: You do not have to give permission to share these records. Chestnut Hill Pediatrics will not base your/the patient's treatment on whether or not you sign this form.

After your/the patient's medical record is shared, this information may be re-disclosed (shared) by the person or organization you listed above. This re-disclosure may not be protected by State and Federal law.

You have the right to a copy of this signed form.