Authorization for the Release of Medical Records via Care Everywhere

Chestnut Hill Pediatrics
Boston Children's
Primary Care Alliance

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Care Everywhere is a tool that Chestnut Hill Pediatrics uses to share medical records with individuals outside of our practice. This tool sends information securely.

Demographics

Patient last name:_____

First name: _____ MI: _____

Patient date of birth: _____

Patient address: _____

City: _____ State: _____ Zip: _____

Authorization

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

Choose one:

❍ **I give my permission** for my/the patient's medical record from Chestnut Hill Pediatrics to be shared with the person or organization listed below. My/the patient's medical record may include patient history, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.

The information shared will NOT include information about behavioral health treatment. The information shared WILL include information about:

- HIV test results
- Results of a genetic test administered for predictive or screening purposes
- Substance abuse treatment information

❍ **I DO NOT give my permission** for my/the patient's medical record from Chestnut Hill Pediatrics to be shared with the person or organization listed below.

Share my/the patient's medical records with:

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address _____

Phone _____ Fax: _____

Name: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address _____

Phone _____ Fax: _____

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. 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 and voluntarily allow my/the patient's medical record to be shared.

Patient's name: _____

Parent/Legal guardian 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.