Consent for Disclosure of Clinical Information to an Outside Provider

Chestnut Hill Pediatrics
Boston Children's
Primary Care Alliance

chestnuthillpeds.com
617-277-2541 | *fax* 617-232-9376

Patient information

Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Phone: _____

Address: _____

City: _____ State:_____

Zip:_____

Authorization

I authorize Chestnut Hill Pediatrics to communicate with the following providers, as needed, to help with evaluation, treatment planning, and coordination of care:

Agency/Organization 1: _____

Name: _____ Degree: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Email: _____

Agency/Organization 2: _____

Name: _____ Degree: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Email: _____

Agency/Organization 3: _____

Name: _____ Degree: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Email: _____

Agency/Organization 4: _____

Name: _____ Degree: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Email: _____

Agency/Organization 5: _____

Name: _____ Degree: _____

Address: _____

City: _____ State: ___ Zip: _____

Phone: _____ Fax: _____

Email: _____

Chestnut Hill Pediatrics has my permission to release information acquired in the course of evaluation and/or treatment of the above named patient, including telephone contact and secure email. I understand the information may include the items initialed below (if applicable).

Please initial all parts you AGREE to have shared

HIV Test Results (Specific approval required for each release request)

Specify dates: _____

Initial: _____

Genetic Screening Test Results

Specify type of test: _____

Initial: _____

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. I can, however, cancel this authorization in writing at any time, except to the extent that Chestnut Hill Pediatrics has relied upon it.

Initial: _____

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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: _____

Confidential Communications with a Licensed Social Worker

Initial: _____

Information related to the use of alcohol, drugs, and/or tobacco

Initial: _____

Information related to a sexually transmitted disease, sexual activity and/or orientation

Initial: _____

Information related to diagnosis or treatment of pregnancy

Initial: _____

Information related to child abuse or neglect

Initial: _____

Information concerning family violence and/or Domestic Violence Victims' Counseling

Initial: _____

Other(s): Please list: _____

_____

_____

Initial: _____

In addition, I give permission to the medical and behavioral health providers of Chestnut Hill Pediatrics to share information with any emergency caregivers who are involved in the care of my child in the event of a medical or psychiatric emergency.

This authorization is voluntary and I have the right to refuse to sign it. Signing this form is not a condition of treatment.

I may take back this authorization at any time by giving written notice of revocation; however such revocation would not affect any action taken by Chestnut Hill Pediatrics in compliance with this authorization before receipt of my written, hard-copy, revocation.

We may accept photocopies or facsimiles of this authorization.

This authorization will expire in 12 months from the date of signing, unless otherwise changed or revoked.

Authorization

Signature of parent/guardian/self (if 13+):

_____

Date: _____

Staff signature: _____

You have the right to have a copy of this form after you sign it.
The original of this form will become part of the clinical record.

Verbal consent

Obtained from parent/guardian/self (if 13+)

Name: _____

❍ via telephone ❍ in-person

Date: _____ Time: _____

Witness #1 name: _____ Title: _____

Signature: _____

Witness #2 name: _____ Title: _____

Signature: _____