Plymouth Pediatric ASSOCIATES
A Preferred Boston Children's Hospital Primary Care Practice

Appendix 1: Consent for Disclosure of Clinical Information to Outside Provider

Demographics

Patient Last Name _____ First Name _____ MI_____

Patient Date of Birth _____

Patient Address _____

Authorization

I authorize **[Provider Name, Degree]** to communicate with the following providers, as needed, to help with evaluation, treatment planning, and coordination of care:

Agency/Organization	Name, Degree	Address	Phone/Email/Fax

[Practice Name] 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 elements you agree to have released

Initial if info **may** be released	**HIV test results** (Specific patient authorization required for each release request) Specify Dates:
Initial if info **may** be released	**Genetic Screening Test Results** (Specify type of test)
Initial if info **may** be released	**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 **[Practice Name]** has relied upon it.

Initial if info **may** be released	**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 released	**Confidential Communications with a Licensed Social Worker**
Initial if info **may** be released	**Information related to the use of alcohol, drugs, and/or tobacco**
Initial if info **may** be released	**Information related to a sexually transmitted disease, sexual activity and/or orientation**
Initial if info **may** be released	**Information related to diagnosis or treatment of pregnancy**
Initial if info **may** be released	**Information related to child abuse or neglect**
Initial if info **may** be released	**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info **may** be released	**Other(s): Please list**

In addition, I give permission to the medical and behavioral health providers of **[Practice name]** 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 **[Practice name]** in compliance with this authorization before receipt of my written, hard-copy, revocation.

You 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.

_____ _____

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 _____ on _____ at _____.
Via telephone/in-person Name of Parent /Guardian /Patient (if 13+) Date Time

Witness # 1 Name/Title _____ Signature _____

Witness # 2 Name/Title _____ Signature _____