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

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI) RECORD RELEASE REQUEST

Part 1: Authorization

Name:	**Date of Birth:**
Address:	**Phone Number:**

By signing this Authorization, I hereby authorize Plymouth Pediatric Associates ("PPA") to release my protected health information ("PHI") as indicated below to the person(s)/agency(s)/facility(s) named in Part 2 of the form (each a "Recipient").

Part 2A: Names of the Recipient(s) to whom PPA may release your PHI

Person/Agency/ Facility Name: _____

Address: _____ Phone Number: _____

Part 2B : Release to PPA from outside Agency

Records from _____ To: Plymouth Pediatric Associates

Part 3: Reason for releasing your PHI

☐ Referral / Medical Care ☐ Facilitate Billing ☐ Obtain insurance, financial, or other benefits
☐ Transferring to an adult provider ☐ Moving (City:_____ State:_____)
☐ Insurance Change (PPA not in network) new network: ☐ Other (please specify):

Part 4: The Types of PHI that PPA may release to the Recipient(s)

If requesting copies of records from PPA, please include dates of service/date range of service as needed

☐ Medical Summary (no charge)
☐ Medical Records from _____ to _____
☐ Entire Record
☐ Other: please specify:

Please indicate if you do <u>NOT</u> want any of the following information disclosed:

☐ Genetic information
☐ HIV/AIDs information
☐ Sexually transmitted diseases
☐ Treatment for alcohol and/or drug abuse

(continued on next page)

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Part 5: By signing below, I understand I am authorizing the use/release of my PHI and

1. My authorization is voluntary and will not affect my ability to obtain treatment from PPA, except if I am (i) receiving research-related treatment or (ii) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from PPA.

2. I understand that PPA may charge a reasonable fee for receiving a copy of the medical record. PPA's fees for records requested by patients is:
   $6.50 for an electronic copy of the records
   $25 for a paper copy of the records
   No charge for medical record summary

3. I understand that PPA cannot guarantee that the Recipient will not re-disclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information.

4. I understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by PPA in reliance on this Authorization before written notice of revocation is received by PPA. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at 148 Industrial Park Rd., Plymouth, MA 02360 or contactus@ppapeds.com.

5. This Authorization will expire: ☐ After this one-time disclosure; **OR**
   ☐ Upon discharge from PPA Services; **OR**
   ☐ _____ (*Insert applicable event or date – mm/dd/yyyy)*

Note: If an expiration event is used, the event must relate to the patient or the purpose of the use or disclosure.

Part 6: Signature of Patient or Patient's Legal Representative

_____ _____
Signature of Patient or Patient's Legal Representative **Date**

_____ _____
Name of Patient's Legal Representative and & Relationship to Patient **Date**

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