Authorization for Use and Disclosure of Health Information/Restriction of PHI

Fellsway Pediatrics
Boston Children's
Primary Care Alliance

fellswaypediatrics.com
781-665-4364

If you are now 18 or older you have become a legal adult, please understand that your parents or legal guardians are no longer considered your legal representative. Under state law and federal HIPAA regulations, you can consent to your own medical care and control your own medical records and information. This means that we can no longer share your records or any medical information about you with your parents, or anyone else, without your written permission.

We do encourage you to continue to discuss, whenever possible, any health problems or concerns with your parents/ legal guardians and to continue to seek their advice. If you would like us to be able to share your information with your parents, legal guardian or anyone else, we ask you to fill out and sign the enclosed consent form. Note that you can specify with whom we can share your information. You can allow us to share all of your health information or only part of it. Please specify any information that you do not want us to share. Make sure to fill in an expiration date or event. You are welcome, of course, to bring your parent with you when you visit us at the office.

Please complete and sign

Patient name: _____

Date of birth: _____

Contact number: _____

E-mail: _____

Person authorized to receive information

By signing this authorization, I authorize Fellsway Pediatrics to use and/ or disclose certain protected health information (PHI) they have about me to the following person(s):

Name of person: _____

Relationship: _____

Name of person: _____

Relationship: _____

I hereby authorize the release of the following to the person(s) listed above:

Check all that apply

❑ My complete health record (Which includes info of ALL PHI check boxes below)

❑ History and Physical Exams

❑ Lab Report

❑ Appointment and Visit Notes

❑ X-Ray Reports

❑ Prescription/Pharmacy Records – Including requesting prescription refills

❑ Alcohol/Drug Abuse Treatment

❑ Mental Health Records

❑ Hospital Notes

❑ Allow the above person(s) to make appointments for you

❑ Other (Please specify): _____

By signing below, I acknowledge that I have read and understand:

- That when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
- The care center may or may not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.
- That I do NOT have to sign this authorization in order to receive treatment.

Patient signature: _____

Date: _____

Print patient name: _____

Relationship to patient: _____