AUTHORIZATION FOR SHARING OF HEALTH INFORMATION

Patient Name	Date of Birth	Telephone #	
Street Address	City	State	Zip

Note: This form must be fully filled out prior to signing. An incomplete form will not be honored.

I hereby authorize the use and disclosure of my/my minor child's individually identifiable health information (personal health information) and records as described below.

Please provide a specific description of your/your minor child's information to be used and/or disclosed (including date(s)) and the reason for sharing this information: (eg. diagnoses, treatment notes, lab/xray reports, consultation reports, therapy notes) ____

____

Due to the sensitive nature of the information, the following items which may be part of your/your minor child's records, must be individually checked to be shared:

- ❑ HIV/AIDS related information and/or records
- ❑ Psychotherapy notes
- ❑ Other mental health information, communications and/or records
- ❑ Information acquired by any social worker consulting with our practice in their professional capacity
- ❑ Communications between myself and any psychotherapist, psychologist or allied mental health professional
- ❑ Treatment notes, communications or other information regarding domestic violence or sexual assault
- ❑ Genetic testing information and/or records
- ❑ Blood alcohol test results
- ❑ Test results for sexually-transmitted disease
- ❑ Status of a child born out of wedlock
- ❑ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)
  Describe: ____
  ____

Please identify the/those person(s)/organization(s) authorized to use or disclose your information:

From: ❑ All providers/therapists at Child and Adolescent Health Specialists, PC
223 Chief Justice Cushing Hwy, Suite 201, Cohasset, MA 02025
❑ Only the specific providers/therapists listed: __________________________
____

Please identify the/those person(s)/organization(s) you authorize to receive your information:

To: Name: ____
Relationship to patient: ❑ Parent ❑ Physician ❑ Therapist
❑ Other ____
Address: ____
Telephone #: ____

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I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations or other applicable state or federal laws.

I understand that Child and Adolescent Health Specialists, PC will not condition my treatment on whether I provide authorization for the requested use and/or disclosure for research-related treatment or treatment that is necessary for the purpose of creating protected health information for disclosure to a third party (e.g. physical exams for school, camp, employment, etc.).

If information is requested by my health insurer and I refuse to sign a required authorization, I understand that the health insurer may in certain instances deny me payment, enrollment or eligibility for benefits.

I understand that I may examine or request copies of any information disclosed by this authorization.

I authorize Child and Adolescent Health Specialists, PC to share information, verbal, written, electronic or as otherwise determined by the Practice (the risks of which have been explained to me), or to review or release pertinent information from my/my minor child's medical information and records including any sensitive medical information, unless otherwise excluded below,* with those listed above.

I understand that I may cancel this consent at any time by notifying Child and Adolescent Health Specialists, PC in writing. However, this cancellation does not affect any actions taken by Child and Adolescent Health Specialists, PC before receiving my written notification. The requested cancellation may take up to thirty (30) days to process.

I hereby release Child and Adolescent Health Specialists, PC, its professionals, employees and agents, from all liability arising from this authorized use and/or disclosure of my health information.

Medical record information will not be shared or released without a valid signature below. Unless cancelled in writing as indicated above, this authorization will expire one (1) year from the signature date.

Signature: ____ Date: _______________
(Parent/Legal guardian if a minor child)

____ _______________________________________
Print Name of Legal Representative (if applicable) Print Patient's Name

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* I consent that Child and Adolescent Health Specialists, PC may share my/my minor child's medical records with the ***EXCLUSION*** of any reference to: (circle all that apply) drug/alcohol usage, venereal disease, abortion, genetic testing, HIV testing, AIDS diagnosis/treatment, mental health treatment, or other protected information: (please specify): _____________
____

Signature: ____ Date: ________________
(Parent/Legal guardian if a minor child)