Needham Pediatrics
Boston Children's
Primary Care Alliance

145 Rosemary St, Entry K, Needham, MA 02494
781-444-7186 / fax 781-449-4617
www.needhampediatrics.com

INDIVIDUAL PATIENT'S AUTHORIZATION

Signing this form confirms your authorization for us to disclose, receive, and use your protected health information for a special purpose.

Confirmation of Authorization

* I give my authorization to disclose, receive and use my child's health information as described below

* I give this authorization voluntarily

Patients; Name: _____

Parent/Guardian Name: _____

Address: _____

Telephone Number: _____

Use and/or Disclosure Authorized:
The specific information you are authorizing us to disclose, receive, and use is:

( ) School Reports ( ) Hospital Reports ( ) Psychological Evaluation

( ) Psych Test Reports ( ) Admissions Reports ( ) Lab Reports

( ) Medical Reports ( ) Discharge Summary ( ) Treatment Summary

( ) Social History ( ) Drug Abuse(past/present)

( ) Other: _____

Name the person and/or organizations that you are authorizing to disclose, receive, and use your protected health information:

_____

Name of healthcare professional: _____

Name of organization: _____

Other: _____

Describe each purpose for which you are authorizing your protected health information to be received, used, and/or disclosed: Information to aid diagnostic assessment, treatment planning and provision of care, and care coordination. This authorization will expire in 12 months from the date of signing, unless otherwise changed and/or revoked.

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION:

I understand that I may revoke this authorization at any time by giving written notice to my clinician and the Practice manager of Needham Pediatrics. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance, the insurance company has a right to contest my claims under the insurance policy.

SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT:

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that I may be required to sign an authorization if my treatment is the result of a court order or other mandate. And under some circumstances, a health plan may condition my enrollment plan or eligibility for benefits on my providing an authorization.

INDIVIDUAL PATIENT/PARENT/GUARDIAN SIGNATURE:

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for release, disclosure and use of the protected health information described in this form with the people and/or organization named in this form:

Signature:_____ Date:_____

*Expiration date will be 1 year from the above unless otherwise noted here:_____

If this authorization form is signed by the parent/guardian for the individual patient:

Parent/Guardian name: _____ Relationship: _____
Print name

Parent/Guardian signature:_____

You have the right to obtain a copy of this form after you have signed it.
The original form will become part of the patient's clinical record