GENERAL RECORDS RELEASE / AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLYMOUTH PEDIATRIC ASSOCIATES, LLC

139 SANDWICH STREET
PLYMOUTH, MA 02360

441 Route 130
SANDWICH, MA 02563

Step 1 - Patient Name: _____ **DOB: _____**

By signing this General Records Release / Authorization for Use or Disclosure of Protected Health Information ("Authorization"), I hereby authorize Plymouth Pediatric Associates, LLC ("PPA"), to release my protected health information ("PHI") as specified herein to the following persons / entities ("Recipient"):

_____
Person(s) / Facility

_____
Address / Contact Information

Step 2 - Request Details

Reason for request:
- ☐ At my request (only patient can check this box).
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For legal matter
- ☐ For employment purposes
- ☐ Other (please specify): _____

Date Range of Services: From __ / __ / __ to __ / __ / __ **or** ☐ **All** Medical Records

☐ **Summary** of record

Please indicate the **specific categories of information** you agree to release by checking and initialing the boxes below:

- ☐ _____ **HIV/AIDS** (specify dates_____)
- ☐ _____ **Sexual Assault**
- ☐ _____ **Sexually transmitted diseases**
- ☐ _____ **Behavioral Health** (Initial intake, most recent treatment plan/ discharge/transfer summary)
- ☐ _____ **Domestic Violence treatment/counseling**
- ☐ _____ **Family planning services**
- ☐ _____ **Psychotherapy notes**
- ☐ _____ **Alcohol or Drug Abuse** (protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WITH WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2)
- ☐ _____ **Other(s): _____**(please specify)

Step 3 - Authorization Terms and Signatures:

I understand and agree that:

1. With my signature the information specified above will be released to the Recipient designated above.
2. The Authorization is valid for 90 days unless I indicate a different time or reason for expiration.
3. Once the information has been released, PPA cannot guarantee that the Recipient will not re-disclose the information to another party who may not be required to comply with state and/or federal laws governing the use and disclosure of PHI and, in such case, the PHI described above may be re-disclosed and would no longer be protected by such laws governing privacy of health information.
4. I may revoke this Authorization at any time except to the extent that the PPA has taken action in reliance on this Authorization. I further understand that I must provide any notice of revocation in writing to the Privacy Officer at the address above.
5. I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment from PPA, except when: (i) my refusal may limit PPA's ability to provide safe and effective care; (ii) I am receiving research-related treatment; or (iii) I am receiving health care solely for the purpose of creating information for disclosure to a third party. If any of these exceptions apply, my refusal to sign an authorization may result in my not obtaining treatment from PPA.
6. There is no fee for a copy of the summary of your record. For other records, I may be expected to pay a small fee to cover the costs of releasing the information as authorized by law. PPA has provided me with information on the amount of such fee.

I have carefully read and understand the terms of this Authorization. I have had the opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby knowingly and voluntarily, authorize the disclosure of the above protected health information to the designated person/entity as specified above. I give my permission to share my protected health information, which may include protected or privileged information, in written and/or other stored format.

Patient (or authorized individual)_____ **Signature** _____

Other name(s) used as a patient: _____Telephone: (_____)____-_____

Address:_____

Street Apt. # City State Zip Code

Date __ / __ / __

If not patient – indicate relationship below:

❑ When patient is under legal age or incompetent to give consent, signature of parent, legal guardian, health care agent (proxy) is required. In such cases, identity and documentation of legal authority must be confirmed.

(Note: Executors requesting records must provide a court order establishing estate executorship with Date of Death: __ / __ / __)

Printed Name: _____ Signature _____Date_____

Relationship to Patient: ❑ Legal Guardian ❑ Legal Representative (please specify) _____

❑ I will pick up the information: ❑ At _____

❑ Please send the information to address below or ❑ via Fax (_ _ _) _ _ _ - _ _ _ _

Name _____ Facility _____
Last First Middle

Address: _____
Street Apt # City State Zip Code

Telephone: (_ _ _) _ _ _ - _ _ _ _

STAFF USE ONLY: ❑ Complete all fields and **attach copy of ID/document** to this form as well as any **court document establishing estate executorship** for legal purposes**.** ❑ **Payment Received $ _____**

Name of Primary Care Provider **_____** MR # _____

Provider Signature: _____ Date __ / __ / __

Identity confirmed/Record Released by: Staff member _____ Date __ / __ / __

Effective 1/1/2016

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