Woburn Pediatric Psychological Services
7 Alfred Street – Suite 100
Woburn, MA 01801
(781) 569-6022

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: Date of Birth:

I hereby authorize Woburn Pediatric Psychological Services to:

[ ] Obtain from: [ ] Release to: [ ] Verbally speak with:

Name: _____ Title: _____

Address: _____ Phone: _____

_____ Fax: _____

The following information (Please check all that apply):

____ Records of mental health care and treatment

____ Records of HIV status and records of care and treatment for HIV/AIDS

____ Records of care and treatment for sexually transmitted diseases

____ Records of care and treatment for abuse

____ Records of substance abuse care and treatment

The purpose of disclosure authorized herein is specifically for
[ ] Coordination of care [ ] Personal Use [ ] Other _____

Method of delivery (if for personal use)
[ ] Mail _____ [ ] Pick up (ID required) [ ] Other _____

Date of expiration (If no date stated, expires when care is terminated): ____/____/_____

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."'

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically on its designated expiration date. I also understand that generally, Woburn Pediatric Psychological Services may not condition my treatment on whether I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

_____ _____
Patient > 18 years or Guardian Signature Date

_____ _____
Patient > 18 years or Guardian Signature Authority/relationship