Woburn & North Andover
pediatric associates & psychological services

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):

Mental health care and treatment	YES	NO	N/A
HIV status and records of care and treatment for HIV/AIDS	YES	NO	N/A
Care and treatment for sexually transmitted diseases	YES	NO	N/A
Care and treatment for abuse	YES	NO	N/A
Substance abuse care and treatment	YES	NO	N/A

other____

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.

____ ______________________________
SIGNATURE: Parent-Guardian OR Patients 18+ years old Date

____ ______________________________
PRINT NAME: Parent-Guardian OR Patients 18+ years old Authority/relationship