Mass General Brigham

Deliver Signed Release Form To:
Sugarloaf Pediatrics
29 Elm Street
South Deerfield, MA 01373

For questions, contact: 413- 665-9111

Authorization for Release of Protected or Privileged Health Information

A. Patient information

Patient Name: _____ Date of Birth: _____

Medical Record #: _____

Address: Street: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____

B. Permission to share: I give my permission to share my protected health information.

Records from:

Name of Site Location: Sugarloaf Pediatrics

Practice Name: Sugarloaf Pediatrics, 29 B Elm Street
South Deerfield MA 01373

Provider Name: _____

Purpose: (check the appropriate box)

- ✓ Medical Care
- ☐ Insurance*
- ✓ Legal*
- ✓ Personal
- ☐ School
- ✓ Other* (please specify) Transition to NAP

**Copying fees may apply*

Send records to (Enter where you would like Mass General Brigham to send your information to):

☐ Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below:

Name: Northampton Area Pediatrics

Address: 193 Locust Street, Northampton, MA 01060

Telephone Number: _____

Send by:
Information will be sent via extract.

C. Information to be released (please check all that apply, and MUST specify dates):

- ☐ Date(s) of Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) _____
- ☐ Date(s) of Clinic Visit Notes _____
- ☐ Date(s) of Discharge Summary _____
- ☐ Date(s) of Lab Reports _____
- ☐ Date(s) of Operative Reports _____
- ☐ Date(s) of Pathology Reports _____
- ☐ Date(s) of Radiation Reports _____
- ☐ Date(s) of Radiology Reports _____
- ☐ Date(s) of Photographs _____
- ☐ Date(s) of Billing Records _____
- ☑ Other: Demographic and scheduling information will be sent in the form of an extract.

SCAN TO: PATIENT\HIM ROI AUTHORIZATION

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D. Please check YES to indicate if you give permission to release the following information if present in your record:

☐ Yes HIV test results (Patient authorization required for each release request.)
Specify dates _____

☐ Yes Genetic Screening test results
Specify type of test _____

☐ Yes Substance Use Disorder Treatment Records Protected by Federal Confidentiality Rules 42 CFR Part 2 (Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.) This consent may be revoked upon oral or written request.

☐ Yes Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC) (I understand that my permission may not be required to release my mental health records for payment purposes)

☐ Yes Confidential Communications with a Licensed Social Worker

☐ Yes Details of Domestic Violence/ Intimate Partner Abuse Counseling

☐ Yes Details of Sexual Assault Counseling

E. I understand and agree that:

- Mass General Brigham cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Mass General Brigham may or may not protect this information once it has been released to the recipient
- This authorization is voluntary
- My treatment, payment, health plan enrollment, or eligibility for benefits will not be affected if I do not sign this form
- I may cancel this authorization at any time by submitting a written request to the Department or Office where I originally submitted it, except:
  - if Mass General Brigham has already processed the request (for example, once information is released, it will not be retrieved)
  - if I signed this authorization as a condition of obtaining insurance. Other laws may provide the insurer with a right to contest a claim under the policy or the policy itself
- This authorization will automatically expire 6 months from the date signed unless otherwise specified:_____
- I understand that if Mass General Brigham maintains any of my records from outside providers, these will not be released unless I specifically ask for them under "Other" in section C. Please include entity name, provider, and specific dates if known.
- My questions about this authorization form have been answered

Patient's Signature: _____ **Date:** _____

Print Name: _____

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative: _____ **Date:**_____

Print Name: _____ **Relationship of representative to patient:** _____

For Internal Use Only: Information Released/Reviewed By: _____Date: _____

Picked up by: _____ Pick-up Identification: ☐ License ☐ State ID ☐ Passport ☐ Other Photo ID _____