PLEASE COMPLETE BOTH SIDES OF FORM

Quincy Pediatric Associates

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

Please print all information clearly in order to process your request in a timely manner.

A. PATIENT INFORMATION

PATIENT NAME: ____**PATIENT DATE OF BIRTH**_______________

PATIENT MEDICAL RECORD # ________________________

PATIENT ADDRESS: **STREET:**____**APT#** ________________

CITY: ___________________________________ **STATE:** _______ **Zip Code:** ____________

TELEPHONE CONTACT # : **DAY:** ( ) ____________________ **EVENING:** ( ) __________________________

B. PERMISSION TO SHARE:

I give my permission to share my protected health information. Enter where you would like information sent from, and to whom you would like the information sent.

FROM:

Quincy Pediatric Associates Inc

PURPOSE: (CHECK THE APPROPRIATE BOX)

[ ] Medical Care [ ] Personal

[ ] Insurance [ ] School

[ ] Legal Matter [ ] Other (please specify)

____

TO:

[ ]Check here if the records are to be mailed to the patient at the above address (section A), otherwise complete the information below to indicate where you would like the information sent:

Name: ______________________________________

Address: ____________________________________

____

Telephone Number: ______________________________

C: INFORMATION TO BE RELEASED (Please check all that apply, and specify dates)

[ ] Medical Record Abstract/dates ______________________________________ **Fee: $10.00**

(e.g. Office notes for the past two (2) years, along with immunizations, labs, problem list, medication list)

[ ] Complete Medical Record **Fee: $ see below**

GENERAL LAWS OF MASSACHUSETTS – PART I. ADMINISTRATION OF THE GOVERNMENT – TITLE XVI. – PUBLIC HEALTH CHAPTER 111. PUBLIC HEALTH – HOSPITALS Chapter 111: Section 70 Records of hospitals or clinics; custody; inspection; copies; fees

S.B. 642, an Act Regarding Medical Record Copying Fees was signed into law by Governor Romney on November 26, 2003 and took effect on July 1, 2004. This bill identifies reasonable fees and establishes acceptable charges for health information that will comply with both federal HIPAA and state regulatory requirements. The term reasonable fee established under this section may be adjusted to reflect the consumer price index (CPI) for medical care services, such that the base amount and the per page charge shall be increased by the proportional CPI in effect as of October of the calendar year in which the request is made, rounded to the nearest dollar. The new fee is as follows:

A base charge of not more than 15.00 dollars for each request for a medical record; a per page charge of not more than (0.50) cents for each of the first 100 pages of a medical record that is copied per request; and not more than (0.25) cents per page for each page in excess of 100 pages of a medical record that is copied per request and the cost of postage and mailing.

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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**

[ ] YES **Genetic Screening Test Result**

[ ] YES **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS XPRESSLY 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 **Other(s):** Please list ____

[ ] YES Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Phycologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC)

[ ] YES Confidential Communications with a Licensed Social Worker (LISW)

[ ] YES Details of Domestic Violence Victims' Counseling

[ ] YES Details of Sexual Assault Counseling

E. I understand and agree that:

- Quincy Pediatric Associates Inc (QPA) cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at QPA 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
- This authorization will automatically expire **6 months from the date signed** unless otherwise specified
- My questions about this authorization 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 to patient: ________________