



Boston Children's Health Physicians

Until every child is well™

formerly CWPW



Authorization for the Release of Medical Information

| | | | |
|--|--|---------------|-------|
| Patient Name: | | Phone Number: | |
| Patient Address: Street, City, State, Zip | | | |
| Date of Birth: | | Mm | dd yr |
| Other identifier (social security number): | | | |

I hereby authorize _____ [health care provider] to disclose or transfer my protected health information as indicated below.

This information is to be disclosed to:

Name:

Attention of:

Street Address:

City, State, Zip

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

For dates of treatment from _____ to _____

REASON FOR REQUESTED USE OR DISCLOSURE:

- Transfer of health coverage Personal use Form completion Referral
- Change in health care provider Other

This authorization expires in one year from the date signed or earlier _____ date

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage
- The disclosing provider will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- The information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA or other privacy laws.
- I acknowledge that I have had an opportunity to review this authorization and understand its intent and use.
- I will receive a copy of this completed and signed authorization form.

There will be a charge of 75 cents per page for copying medical records plus cost of mailing.

| | |
|--------------------|-------|
| Patient Signature: | Date: |
|--------------------|-------|