Pioneer Valley Pediatrics, Inc.

☐ *123 Dwight Rd*
Longmeadow, MA 01106
413-567-1031
413-567-7683 - Fax

☐ *115 Elm St*
Enfield, CT 06082
860-745-3336
860-741-2654 - Fax

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name ____ Phone _______________________________________

Address ____

Date of Birth _________________________

☐ I hearby authorize Pioneer Valley Pediatrics to disclose the following heatlh information to :

Name ____

Address ____

Phone # ____ Fax# ____

☐ I hereby authorize:

Name ____

Address ____

Phone # ____Fax#_____________________________________

to disclose the following health information to Pioneer Valley Pediatrics, Inc.

1. Information to be disclosed:

☐ Medical records from this date_________________________________ to this date _________________________

☐ Entire medical record comments: ____

2. Purpose for release of records: ____

3. To the extent applicable, I understand that my medical record may contain information that is considered sensitive under the law. My check marks)s) below indicate(s) that I do NOT permit information of this type, if it exists, to be released. I understand that if I do not check the box, Pioneer Valley Pediatrics, Inc will release such information about me if it exists.

☐ HIV/AIDS infection ☐ Mental Health ☐ Treatment for alcohol and/or drug abuse

☐ Sexually transmitted diseases ☐ Other: Please Specify____________________

4. I understand my records are protected under the federal privacy laws and regulations and under state law, and cannot be disclosed without my written consent except as otherwise specifically provided by law.

5. It is my understanding that this authorization will expire in one (1) year from the date signed below. I understand that I may revoke this authorization by notifying Pioneer Valley Pediatrics. I undertand that any priviously disclosed information would not be subject to revocation request.

6. I undertstand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.

7. I understand that I may inspect or obtain a copy of the PHI described by this authorization.

8. There may be a medical record fee of $.25/page.

This form must be fully complete before signing.

____

Signature of Patient or Patient's Legal Representative Date

____

Print Patient's Name

____

Print Name of Legal Representative (if applicable) Relationship to Patient