

Release of Information Two Way



Patient information

Name: _____

Other Names: _____

Street: _____ Apt #. _____

City/Town: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone: _____

Authorization to Release:

I authorize the Brookline Pediatrics (BKP) to receive and release information, including confidential communications, from or to the Person, Agency or Facility named below, either verbally or in writing.

Person, Agency or Facility (e.g., name and address of hospital, outpatient provider, residential program, other)

Name: _____

Attention: _____

Street: _____

City/Town: _____

State/Zip Code: _____ Phone: _____

Fax: _____ Email: _____

Check to indicate the information you want shared: (check all that apply)

- Mental Health Diagnosis and Treatment provided by a Psychiatrist; Psychologist; Mental Health Clinical Nurse Specialist; Licensed Social Worker Counseling; all other Licensed Mental Health Providers.
- Entire Mental Health Record, excluding Psychotherapy Notes which require a separate authorization
- Entire Record (Medical and Mental Health)
- Other (please specify) / additional information:

Dates of the information you want shared: (Specify dates)

Dates of Requested Information:

From: _____ To: _____

Patient/Applicant Name: _____

Please initial to indicate you give permission to release the following information if present in your record: (initial all that apply)

Initial Here: _____ HIV test results (Authorization required for each release request.)

Initial Here: _____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2 Federal rules prohibit any further disclosure of this information unless disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Purpose of the Release: (must check one)

- Personal Use Coordinate care Referral
- Facilitate billing Obtain insurance, financial or other benefits
- Other purpose (please specify):

I understand that :

- I have a right to revoke this authorization at any time.
- If I revoke this authorization, I must do so in writing and present it to BKP at the BKP address identified on page one.
- The revocation will not apply to information that has already been released pursuant to this authorization.
- The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Once the above information is released, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations.
- Authorizing the disclosure of the information identified above is voluntary.
- I need not sign this form to receive treatment or services from BKP and/or the other named person, facility or agency; however, lack of ability to share or obtain information may prevent BKP, and/or the other named person, facility or agency, from providing appropriate and necessary care.

This authorization will expire (specify a date, time period or an event)

or, if nothing is specified, it will expire one year from date of signing.

Signature / Authorization: Sign and provide information as required below.

Patient Signature (13+) or Parent/Guardian signature (under 13)

Date: _____

Print name of signer: _____

The following information is needed if signed by a parent/guardian:

Relationship to patient: : _____

Distribution of copies: Original retained by BKP; copy to the individual or personal representative.