AUTHORIZATION

Disclosure of Behavioral Health Clinical Information

Newton-Wellesley Family Pediatrics
Boston Children's
Primary Care Alliance

617-965-6700 | *fax* 617-965-5239

Patient name: ____

Date of birth: ____

I authorize Newton-Wellesley Family Pediatrics to communicate with the following providers, as needed, to help with evaluation, treatment planning and coordination of care:

Person/Agency #1: ____

Phone: ____________________ Fax: _________________________

Email: ____

Role (select one):

❍ Therapist

❍ Medication prescriber

❍ School personnel

❍ Other: ____

Person/Agency #2: ____

Phone: ____________________ Fax: _________________________

Email: ____

Role (select one):

❍ Therapist

❍ Medication prescriber

❍ School personnel

❍ Other: ____

Person/Agency #3: ____

Phone: ____________________ Fax: _________________________

Email: ____

Role (select one):

❍ Therapist

❍ Medication prescriber

❍ School personnel

❍ Other: ____

Person/Agency #4: ____

Phone: ____________________ Fax: _________________________

Email: ____

Role (select one):

❍ Therapist

❍ Medication prescriber

❍ School personnel

❍ Other: ____

Authorization

Newton-Wellesley Family Pediatrics has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient, including telephone contact.

Email authorization

Newton-Wellesley Family Pediatrics has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient via email. ❍ No ❍ Yes

Please check the protected health information below that you are authorizing to be used and/or disclosed:

❑ Social/Family history

❑ School related information

❑ Neuropsychological reports

❑ ER visits/Hospitalizations

❑ Alcohol and substance abuse/treatment*

❑ HIV/AIDS related*

❑ Information related to a sexually transmitted infection, sexual activity and/or orientation

❑ Other(s), please list:

____

*HIV and Substance Abuse information is protected under federal law and must be authorized specifically in order to be use/disclosed.

This authorization will expire with the completion of treatment, unless otherwise changed and/or revoked.

I understand that I may revoke this consent at any time, and that I must notify Newton-Wellesley Family Pediatrics in writing. I understand that such a revocation does not affect any action taken by Newton-Wellesley Family Pediatrics prior to receiving my written notice.

Signature

Signature of parent/legal guardian, or patient if 13 or over:

____

Printed name: ____

Date: ____

Acknowledgement of electronic signature: ❍ No ❍ Yes