Boston Children's Hospital

Use Plate, Label, or Print:

Name:

BCH MRN#:

DOB: Gender: M F

AUTHORIZATION FOR RELEASE AND COLLECTION OF PATIENT INFORMATION

To allow Boston Children's Hospital to release information to, discuss information with, or receive information from others, please complete and sign this form and return it to:

Boston Children's Hospital
300 Longwood Avenue
Boston MA 02115

You may submit this form by Fax to: _____

If you need help completing this form, please contact: _____

_____

Patient Information					
Patient Last Name		**First Name**		**MI**	
Street Address				**Apt#**	
City		**State**		**Zip**	
Children's MR#		**Home Telephone**	( )		
Date of Birth		**Alternate Telephone**	( )		

Boston Children's Hospital has my permission to release to, discuss with, and/or receive from the person/ organization (named below) the following information about the above named patient:

Information (please be specific):

Restrictions and/or Exclusions (if any):

Purpose of Release/Collection:

FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURES IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. I can however, cancel this authorization in writing at any time, except to the extent that Children's has relied upon it.

Boston Children's Hospital will release to, discuss with, and/or collect information from the following party:

(Initial below)	**Name**			
Release To	**Attention of**		**Telephone**	
Discuss With	**Street Address**		**Suite/Room**	
Collect from	**City**	**State**		**Zip**

I hereby authorize Boston Children's Hospital (Children's) to release and collect information as requested above. This may include information about drug or alcohol use, psychiatric, social work, or other protected information unless otherwise excluded, except psychotherapy notes. I am aware that Children's cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at Children's may or may not protect this information once it has been disclosed to the recipient. Information will not be released without a valid signature below.

This authorization will end (enter date or event): _____

I can however, cancel this authorization in writing at any time, except to the extent that Children's has relied upon it. For example, if I cancel it after Children's has sent requested records, Children's will not retrieve those records. Instructions for canceling this authorization are included in the Children's Notice of Privacy Practices. I understand that Children's will continue to provide care, even if I do not authorize this release.

Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or a special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.		
Signature of Patient		**Date**
Signature of Parent or Guardian	**Relationship to Patient**	**Date**

Please make a copy of this release for your records.