CENTRE PEDIATRIC ASSOCIATES, P.C.
One Brookline Place, Suite 327
Brookline, MA 02445
(617) 735-8585
Fax (617) 232-0572
www.centrepediatrics.com

Dear Parent:

To obtain a copy of your child's medical records, please complete the enclosed authorization form, sign it in front of a witness who also should sign it, and mail it back to:

Centre Pediatric Associates, P.C.
Attn: Medical Records
One Brookline Place
Brookline, MA 02445-7294

Please do not fax it to us because we need an authorization form with your original signature.

Please note that for each child's records there is a processing fee of $15.00, an amount established by state law. When you return the authorization form, we ask that you send a check payable to Centre Pediatric Associates, P.C. If you would like to pay by credit card, you may complete the credit card information section below and return this letter to us.

When we receive the completed authorization form from you, we will process your request as soon as we can. It takes approximately 7-10 business days for us to prepare your child's medical records.

We encourage you to have your child's records sent directly to you or, even better, to pick up your records at our office rather than to have us send them to a medical facility or office. In this way, we avoid loss of records in the mail, and you will be able to make a copy of the records to keep for yourself.

If you have any questions, please call and ask to speak with our medical records coordinator.

Sincerely,

Karen J. Dias
Practice Administrator

Credit Card #: _____

Security Code # (on back of card): _____

Expiration Date: _____

Print Name on Card: _____

Signature of Cardholder: _____

CENTRE PEDIATRIC ASSOCIATES, P.C.

AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED INFORMATION

PLEASE PRINT:
Patient Name: _____ Patient Date of Birth: _____

Parent or Legal Guardian: _____

Address: _____

_____

_____

Telephone: H) _____ W) _____

I, _____ am the parent or legal guardian (or patient if over 18 years of age) of the above-named patient. I do hereby authorize Centre Pediatric Associates, P.C. to release health information including copies of my medical record to the following person(s) or classes of persons at the locations/facilities listed, for the purposes described:

Person/Class of Person	Location/Facility	Purpose *(check the appropriate box)**
_____	_____	☐ Medical/Surgical Care
	_____	☐ Legal Matter
	_____	☐ Insurance
	_____	☐ Personal
		☐ Other *(please specify)* _____

- ***Please refer to the Centre Pediatrics Privacy Notice for information on copying fees that may be associated with copying your records for some of these purposes***

INFORMATION TO BE RELEASED (*Please check all that apply and specify dates):*

☐ Well Visit Notes From: _____To: _____

☐ Growth Charts From: _____To: _____

☐ Immunization Records From: _____To: _____

☐ Sick Visit Notes From: _____To: _____

☐ Lab reports From: _____To: _____

☐ Triage Nurse Notes From: _____To: _____

☐ Other *(please specify)* _____ From: _____To:_____

I request the release of the specifically protected or privileged categories of information that I have *INITIALED* below:

_____ HIV test results (Patient Authorization Required for Each Release Request) **Specify Date(s)** _____
_____ Alcohol and Drug Abuse Records Protected by Federal Confidentiality Rules 42 CFR Part 2
(Federal Rules prohibit any further disclosure of this information unless further disclosure is expressly permitted or written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.)
_____ Other(s): Please List _____

Confidential Details of:
_____ Psychotherapy notes (notes recorded by a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling, and that are separate from the medical record)
_____ Other professional services of a licensed psychologist
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling
_____ Venereal Disease
_____ Abortion
_____ Other

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Office Manager at Centre Pediatric Associates. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization
- If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and no longer protected by this rule
- I understand that this authorization will automatically expire: ***(please check one)***:
  - ☐ in 3 months
  - ☐ in 6 months
  - ☐ 1 year from this date
  - ☐ upon a specific event ***(specify event)*** _____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Signature of Parent/Guardian or Patient if 18 Years or Older:

_____

Date: _____

Relationship to patient_____

Signature of Witness: _____