1 Brookline Place
Suite 327
Brookline, MA 02445

Phone: (617) 735-8585
Fax: (617) 232-0572

TWO-WAY RELEASE AND EXCHANGE OF INFORMATION AUTHORIZATION FORM

Patient Name: ____ Date of Birth: ___________________

Address: ____

AUTHORIZATION TERMS

- This authorization permits two-way (bidirectional) communication between Centre Pediatric Associates and the facility listed below.
- Information may be shared via phone, fax, secure email, or written reports as appropriate.

I give permission for disclosure of my/my child's individually-identified health information and communication between the individuals listed below.

Centre Pediatric Associates
Name: _________________________
Phone: (617) 735-8585
Fax: (617) 232-0572

Other Party Info:

Practice: ______________________________
Name: ____________________________
Phone: ___________________
Fax: _____________________
Email: ____________________________

PURPOSE OF DISCLOSURE (CHOOSE ALL THAT APPLY)

☐ Coordination of Care ☐ Referral ☐ Other: ___________________________________

INFORMATION TO BE SHARED (CHOOSE ALL THAT APPLY)

☐ ALL
☐ Immunization records/Growth Charts
☐ Office Notes
☐ Lab/Radiology/Test Results
☐ Care Plans (e.g., Asthma, Allergy)
☐ Hospital Records
☐ Mental Health Records
☐ Surgical Reports
☐ Other: ____

EXPIRATION

This authorization will expire (check one): ☐ Date: ____ /____ /______ ☐ Other: ___________________

If I fail to specify an expiration date or event, and unless otherwise revoked, this authorization will expire *ONE YEAR* from the date signed below.

RIGHT TO REVOKE

I understand that:

- I may revoke this authorization at any time in writing, except to the extent action has already been taken.
- Authorizing the disclosure of this health information is voluntary.

PARENT SIGNATURE

Parent/Guardian Name (print): _________________________________

Signature: __________________________________ Date: __________

PATIENT SIGNATURE (IF PATIENT 18 YEARS OR OLDER)

Patient Name (print): ____

Signature: __________________________________ Date: __________