Boston Children's Hospital

Signed form may be faxed to: 617-730-0327, or mailed to:
HIM/Medical Records
Boston Children's Hospital
300 Longwood Avenue
Boston, MA 02115

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION
Page 1 of 2

Please complete this form and sign on page 2 where indicated.

If you have questions related to this form, contact HIM/Medical Records at 617-355-7546

Demographics

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

I authorize Boston Children's Hospital to release my/my child's protected health information including copies of my medical record of care to the following person(s) at the address/facility listed below:

Name/Facility
Catastrophic Illness in Children Relief Fund, MA Dept of Public Health

Attention	**Telephone** (617) 624-5951
Address Suite/Room 250 Washington Street, 5th Floor	**Fax** (857) - 323-8322
City/State Boston, MA	**Zip** 02108

PURPOSE OF RELEASE (check the appropriate box below)

- ☐ Medical Care
- ☐ School or Camp
- ☐ Insurance*
- ☐ Personal *
- ☐ Legal Matter*
- ☑ Other (please specify)

To determine eligibility for CICRF Fund Assistance

* Please refer to the Boston Children's Hospital Notice for information on copying fees that may be associated with this request. There may be additional charges for copies of photographs.

FORMAT OF RELEASE
(please check the appropriate box below)

- ☐ CD
- ☐ Paper
- ☑ Fax (to MD Office only)
- ☑ Electronic (cicrf.dph@mass.gov)
- ☐ Phone

INFORMATION REQUESTED

DATE RANGE for information needed: _____ - Present

☐ Entire Medical Record (charges may apply)
☐ Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)
☐ Pathology Materials (please specify materials requested and date(s) of surgery: _____
☑ Other – Specify information to be released: _____

Discharge Summaries
Cadence Reports

(OFFICE USE ONLY:) ☐ File ☐ Release as specified above

BOSTON CHILDREN'S HOSPITAL, 300 LONGWOOD AVE., BOSTON, MA 02115

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SEE PAGE 2 ON REVERSE SIDE

Please complete both sides of this form and sign and date at the bottom of page 2

Boston Children's Hospital has my permission to release information contained in the Medical Record of the patient named on this form. I understand the information may include the items initialed below (if it is in your/your child's medical record):

PLEASE INITIAL ALL ELEMENTS YOU AGREE TO HAVE RELEASED

Initial if info may be released	**HIV test results** (SPECIFIC PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST) SPECIFY DATES:
Initial if info may be released	**Genetic Screening Test Results** (SPECIFY TYPE OF TEST)
Initial if info may be released	**Alcohol and Drug Abuse Treatment Records** Protected by Federal Confidentiality Rules 42 CFR Part 2
	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 PART2. I can, however, cancel this authorization in writing at any time, except to the extent that Children's has relied upon it.
Initial if info may be released	**Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC).**
	I understand that my permission may not be required to release my mental health records for payment purposes.
Initial if info may be released	**Confidential Communications with a Licensed Social Worker**
Initial if info may be released	**Information related to a sexually transmitted disease**
Initial if info may be released	**Information related to diagnosis or treatment of Hepatitis**
Initial if info may be released	**Information related to diagnosis or treatment of Pregnancy**
Initial if info may be released	**Information related to spouse abuse and/or child abuse or neglect**
Initial if info may be released	**Information concerning family violence and/or Domestic Violence Victims' Counseling**
Initial if info may be released	**Contain information regarding rape and/or Sexual Assault Counseling**
Initial if info may be released	**Other(s): Please list**

I hereby authorize Boston Children's Hospital (Children's) to release any medical 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 expire 12 months from the signature date, unless otherwise specified: _____ /_____ /_____ 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 the requested records, Children's will not retrieve those records. Instructions for canceling this authorization are included in the Boston Children's Hospital 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	**Name of Patient (please print)**	**Date**
Signature of Parent or Guardian	**Relationship to Patient**	**Date**