FRANCISCAN CHILDREN'S ***30 Warren Street, Brighton, MA 02135*** ***(617) 254-3800 x 1970 FAX: 617-779-1269*** ***Medical Records Department***	Franciscan Children's *So every kid can.*

Section 1: AUTHORIZATION for RELEASE of MEDICAL RECORD INFORMATION (ROI)

Patient:	Date of Birth:	MR#
Patient's Street Address:	City:	Zip code:

I hereby authorize: Franciscan Children's to (please check one): □ RELEASE TO □ OBTAIN FROM

MD/Facility/School: Street Address: City: Zip code: Attention:	Other: Street Address: City: Zip code: Attention:

Section 2: DATES OF SERVICE/TREATMENT *From:* *To:*

Section 3: PURPOSE OF DISCLOSURE

□ **MEDICAL CARE** Admission Summary Discharge Summary Treatment Plan most recent X-ray, most recent Lab, EKG, Consults, Therapy evaluations	□ **DISABILITY ELIGIBILITY** Admission Summary Discharge Summary Treatment Plan EKG, X-ray, Labs Consults, Therapy evaluations	□ **IEP/EDUCATION** Planning Evaluation Report(s) □ **SPED** Education Materials □ **SCHOOL/SPORTS/ CAMP** Immunizations Physical (most recent)	□ **DENTAL CARE** OP report Anesthesia record Tooth form □ **LEGAL** □ Certified for Court □ Subpoena	□ **INSURANCE/ PAYMENT** Admission Summary Discharge Summary Treatment Plan most recent X-ray, most recent Lab, EKG, Consults, Rehab/Therapy evaluations	□ **Additional info CHECK below:** □ Outpatient notes □ Evaluations(therapy) □ Lab □ Genetic testing □ Neuropsych eval □ Educational info □ **OTHER**:

Section 4: AUTHORIZATION CONDITIONS:

This authorization shall be in effect for 120 days following the date of signature. I understand that this authorization may be revoked at any time by written notice to the facility unless action based on it has already occurred. A photocopy or facsimile of this authorization shall constitute a valid authorization. I understand that the person/facility/agency receiving the information may re-disclose it and the information may not be protected by privacy laws or regulation. I understand use or disclosure of information is voluntary and I do not need to sign to receive treatment or services.

Section 5: **If your record contains protected/sensitive information (listed below) check appropriate boxes to identify the information you wish to have INCLUDED in the release or EXCLUDED from the release.**

□ I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of protected health information about my condition and treatment which may include **Psychiatric records (e.g. Neuropsych Eval, behavioral health therapy, Social Service),** to those persons/agencies named above.

□ I do not consent to the release of **Psychiatric records**.

□ I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of protected health information about my condition and treatment which may include **Sexually transmitted diseases (STDS)**, to those persons/agencies named above.

□ I do not consent to the release of **Sexually transmitted diseases**.

□ I have carefully read and understand the above statements and do herein expressly and voluntarily consent to disclosure of protected health information about my condition and treatment which may include **Sensitive information** (e.g. genetic testing/counseling, abuse, violence, sexual assault) to those persons/agencies named.

□ I do not consent to the release of **Sensitive information**.

□ **HIV Release of Information.** To the extent that my medical record contains information concerning HIV (HTLV-III) antibody and antigen testing that is protected by M.C.L. Ch. 111 § 70f, I authorize disclosure of such information for the following purpose:_____

□ I do not consent to the release of **HIV information**.

Section 6: SIGNATURE & DATE: PRINTED NAME:

(CHECK ONE) □ Patient (if 18 or older/or emancipated minor) □ Legal Guardian (additional documentation required)
□ Parent (if patient is under 18) □ Health Care Agent (additional documentation required)

WITNESS SIGNATURE & DATE: **PRINTED NAME:**