**TLC Pediatrics Revere**
**280 Beach Street**
**Revere, MA 02151**
**(P)781-289-5057**
**(F)781-289-4485**

**TLC Pediatrics Everett**
**391 Broadway Suite 301**
**Everett, MA 02149**
**(P)617-389-2121**
**(F)617-389-4194**

## Authorization for Disclosure of Clinical Information for Patients 18+ years or older

Patient Last Name _____ First Name _____

Patient Date of Birth _____

Patient Address _____

**Authorization**

**Section A**

I **do not authorize** communication between TLC Pediatrics and my parents or former legal guardians.

| | |
|---|---|
| Initial if you are declining communication | I understand that I am responsible for all communication with TLC Pediatrics including but not limited to the scheduling/canceling of my appointments, prescription refills and referral requests, and paying **any bills not covered by insurance** |

**Section B**

I **authorize** TLC Pediatrics to communicate with the following person(s).

| Person | Relationship to me | Address | Phone |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**TLC Pediatrics** has my permission to release information acquired in the course of evaluation and/or treatment of the above named patient, including telephone contact and secure email. I understand the information may include the items initialed below (if applicable).

**Please initial all elements you AGREE to have released,**

| | |
|---|---|
| Initial if info may be shared | Information related to a sexually transmitted disease, sexual activity, and/or orientation |
| Initial if info may be shared | Information related to diagnosis or treatment of pregnancy |
| Initial if info may be shared | Information related to contraception and birth control prescriptions |
| Initial if info may be shared | HIV test results (Specific patient authorization required for each release request) Specify dates: |

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| | |
|---|---|
| Initial if info may be shared | Information related to the use of alcohol, drugs, and/or tobacco |
| Initial if info may be shared | Confidential communications with a social worker |
| Initial if info may be released | Alcohol and Drug Abuse Treatment Records |
| Initial if info may be shared | Details of Mental Health Diagnosis and/or Treatment |
| Initial if info may be shared | Genetic Screening Test Results (Specify type of test) |
| Initial if info may be shared | Information related to child abuse or neglect |
| Initial if info may be shared | Information concerning family violence and/or Domestic Violence Victims Counseling |

In addition, I give permission to the medical and behavioral health care providers of **TLC Pediatrics** to share information with any emergency caregivers who are involved in my care in the event of a medical or psychiatric emergency.

This authorization is voluntary, and I have the right to refuse to sign in. Signing this form is not a condition of treatment.

I may take back this authorization at any time by giving written notice of revocation, however such revocation would not affect any action taken by **TLC Pediatrics** in compliance with this authorization before receipt of my written hard-copy revocation.

This authorization will expire 12 months from the date of signing, unless otherwise changed or revoked.

Signature of patient: _____ Date: _____

**You have the right to have a copy of this form after you sign it. The original of this form will become part of the clinical record.**