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

Demographics

Patient Last Name: _____ *First Name:* _____

Patient Date of Birth: _____

Patient Address: _____

Authorization

I give my permission for ***TLC Pediatrics*** *to* ***share with ( ) obtain from ( )*** *my/my child's medical record to the person or organization listed below. My/My Child's medical record may include patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.*

Obtain/Send a copy of my/my child's medical records from/to:

Name: _____ *Organization:* _____

Address: _____

Phone: _____ *Fax:* _____

Please send a copy of my/my child's medical records to: (Choose office below, if applicable)

TLC Pediatrics Revere *280 Beach Street* *Revere, MA 02151* *(F)781-289-4485*		*TLC Pediatrics Everett* *391 Broadway Suite 301* *Everett, MA 02149* *(F)617-389-4194*	

Choose one:

☐ *Medical Record* ***(except confidential information defined by Massachusetts law)***

☐ *Medical Record for the time from* _____ *to* _____

☐ *Only information from a certain illness or injury.*

Please Describe: _____

Under Massachusetts privacy laws, a separate consent is needed to share information about these topics:

- Alcohol/drug use, abuse and/or treatment
- Treatment for mental illness and/or social services communications
- History of venereal (sexually transmitted) or other communicable disease(s)
- Results of tests for HIV/AIDS

Please initial all parts you agree to have shared. (SEE NEXT PAGE)

By putting my initials by each item below I give permission for ***TLC Pediatrics*** to share ( ) obtain ( ) this type of information. I understand that if I do not initial the box, **TLC Pediatrics** *will not share this information about me/the patient's health to the person or organization listed above.*

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Initial if info may be shared	**HIV test results** (Specific approval required for each release request) Specify dates:
Initial if info may be shared	**Genetic Screening Test Results** (Specify type of test)
Initial if info may be shared	**Alcohol and Drug Abuse Treatment Records**
Initial if info may be shared	**Details of Mental Health Diagnosis and/or Treatment provided by a Psychiatrist, Psychologist, Mental Health Clinical Nurse Specialist, or Licensed Mental Health Clinician (LMHC)**
Initial if info may be shared	**Confidential Communications with a Licensed Social Worker**
Initial if info may be shared	**Information related to the use of alcohol, drugs, and/or tobacco**
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 the diagnosis or treatment of pregnancy**
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**

By signing below, I agree that I understand the above and voluntarily allow my/my child's medical record to be shared.

Patient's Name: _____

Parent/Legal Guardian Name: _____Relationship to pt: _____

Signature of Patient: (Parent/Legal Guardian if applicable)

_____ Date: _____