Elizabeth F. O'Connor, MD
Elizabeth J. Tisei, MD
Andrew R.A. Saluti, DO
Julianne Viola, MD
George P. Atkinson, MD
Anuja Khettry, MD
Brenna H. Chase, MD

ROSLINDALE PEDIATRIC ASSOCIATES, P.C.
PEDIATRICS AND ADOLESCENT MEDICINE

2020 Centre Street, Boston, MA 02132
Phone: (617) 522-3100
Fax: (617) 522-6366

Lisa M. Grossi, CPNP-PC
Jennifer Byrne, CPNP-PC
Amy Delaney, CPNP-PC
Katherine Williams, CPNP-PC
Lisa Eyre, CPNP-PC
Emily Kline, PHD

Authorization for the Release of Protected Health Information

Patient Name_____ DOB _____

Address_____ Phone_____

_____

Please allow up to 14 Business Days to Complete. Fee is $20 per Child

I authorize RPA to release my Protected Health Information (PHI), including copies of my medical records to:

Name_____

Address_____

❑ Mail USB Device ❑ Pick up (ID required) **NOTE:** We cannot fax or email entire medical record.

Information to be Released (choose one)

❑ Medical Record (Including pertinent medical summary, growth curves & office notes, with exception of confidential information defined by Massachusetts law.)

❑ Only information from a certain illness, injury, or specific time period. Please Describe:_____

❑ Other – Please Describe: _____

I understand that my medical record may contain some highly confidential information. By my INITIALS below, I am specifically authorizing its release:

_____ Sexually Transmitted Disease _____ Genetic Testing _____ Mental Health/Psychiatric Treatment
_____ Sexual or Physical Abuse _____ Abortion _____ Domestic Violence
_____ Substance Abuse

Reason for Release

❑ **Transfer out of Roslindale Pediatric Associates** – I understand that once records are sent to the new practice/provider, my account at RPA will be deactivated and I will no longer be considered a patient at RPA. Therefore, medical treatment will not be available by any provider at RPA.

❑ **Medical Care by another Provider**

❑ **Insurance / Workers Compensation / Personal Injury, etc.**

❑ **Other – Please Describe:** _____

Acknowledgements

- I understand that I can withdraw my authorization any time by indicating in writing to the Practice Manager, as long as action has not already been taking to release it.
- I understand that the PHI requested via this authorization may be released by the recipient/receiver to another party and may no longer be protected by privacy rules.
- I understand that if I refuse to sign this form, I will not be refused treatment and my payment, health plan, enrollment or eligibility will not be affected.

I have carefully read and understand the above and am authorizing disclosure of my PHI to the person or agency listed above. I understand that this authorization is good for 90 days or until date indicated below:

Please Print Requestor's Name here: _____

Signature: _____ Date: _____

❑ Parent/Guardian ❑ Patient (18+ years old) ❑ Other – Please Explain _____