Authorization to Communicate Health Information

Belmont Cambridge Health Care
Boston Children's
Primary Care Alliance

Ph: 617-491-5111 Fax: 617-491-5222

Patient Information

Last Name:_______________________________________

First Name________________________________

Date of Birth:________________

Address:___________________________ Apt#:_______

City:_________________ State:________ Zip:__________

I authorize **Belmont Cambridge Health Care including the providers, staff or nurses** to disclose my child's health information excluding the following below.

Name:____

Phone:____

Relationship:_____________________________________

Name:____

Phone:____

Relationship:_____________________________________

The following categories of information **will not be released** unless I indicate my authorized by initialing next to the corresponding category(ies):

Adoption______ Mental Health________

Drug Treatment_______ Alcohol Treatment_____

Genetic Test Results__________

Termination of pregnancy_____

Sexually Transmitted diseases_________

HIV Testing/Treatment Records_______

This authorization will only last from:

Date:________________to __________________
Or
Indefinitely (please circle)

Acknowledgment

This approval will remain in effect until the patient leaves Belmont Cambridge Health Care unless otherwise indicated by patient and/or parents/guardians from above.

Signature of parent/guardian, or patient if over 18:

____

Date: ____