18 YEARS AND OLDER

Release of Information

Cape Cod Pediatrics
Boston Children's
Primary Care Alliance

capecodpediatrics.com
508-477-5306 | *fax* 508-477-0297

Last name: _____

First name: _____ MI: _____

Date of birth: _____

I give consent for a copy of my most recent physical, which includes immunizations, to be released to the following:

❍ **Yes** ❍ **No**

❑ School

❑ Daycare

❑ Camp/Sports

❑ Other (please specify): _____

I authorize Cape Cod Pediatrics to speak with the following regarding any BILLING issues:

❍ **Yes** ❍ **No**

Person 1: _____

Person 2: _____

Person 3: _____

I authorize Cape Cod Pediatrics to speak with the following regarding MEDICAL information, including but not limited to, appointments, prescriptions, labs, etc:

❍ **Yes** ❍ **No**

Person 1: _____

Person 2: _____

Person 3: _____

Redisclosure

I understand that any disclosure of information carries with it the potential for redisclosure and the information may not be protected by federal confidentiality rules.

Right to revoke

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I understand that the revocation will not apply to information already released based on this authorization.

Other rights

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed.

Authorization

Signature: _____

Date: _____

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED OR AMENDED