

UNDER 18

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 child's most recent physical, which includes immunizations, to be released to the following:

- Do not release**
- Can release to the following:**
 - School
 - Camp/Sports
 - Other (please specify): _____

I authorize Cape Cod Pediatrics to speak with the following:

- Not applicable**
- Can speak with the following:**

Person 1: _____

Person 2: _____

Person 3: _____

I authorize the following to seek treatment for my child at Cape Cod Pediatrics:

- Not applicable**
- Can seek treatment:**

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 of parent/legal guardian*:

Date: _____

* If legal guardian, please provide CCP with current legal documentation.

**THIS AUTHORIZATION WILL REMAIN IN EFFECT
UNTIL REVOKED OR AMENDED**