Pediatrics at Newton Wellesley

John Cohen, MD, FAAP
Eileen Kramer, MD, FAAP
Susan Reuter, MD, FAAP
Tetiana Pronchick, MD, FAAP
Michael Elkort, MD, MA, FAAP
Qian Yuan, MD, PhD, FAAP
Brinda Trivedi Gupta, MD, FAAP

Genevra Casais, RN, MSN, CPNP
Rachel Sarasohn, RN,MSN, CPNP
Nicole Hersel, RN, MSN, CPNP
Kathleen James, RN, MSN, CFNP
Kayla O'Brien, RN, MSN, CPNP

Authorization for Disclosure of Clinical Information to Outside Provider

Patient Name: _____ DOB: _____

I authorize Pediatrics at Newton Wellesley, P.C. to communicate with the following providers, as needed, to help with evaluation, treatment planning and coordination of care:

Person/Agency	**Role** (check one)	**Phone/Fax/Email (if applicable)**
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	
	❑ therapist ❑ medication prescriber ❑ school personnel ❑ other :_____	

Pediatrics at Newton Wellesley, P.C. has my permission to release information/records acquired in the course of ongoing mental health assessment, evaluation and/or treatment of the above named patient, including telephone contact and email (if applicable please indicate if consenting to email communication ❑ yes ❑ no). Please check the protected health information below that you are authorizing to be used and/or disclosed:

❑ Details of Mental Health Diagnosis and/or Treatment provided by a Mental Health Provider

❑ Social/Family History ❑ School Related Information

❑ Neuropsychological Reports ❑ ER Visits/Hospitalizations

❑ Alcohol and Substance Abuse/Treatment* ❑ HIV/AIDS Related*

❑ Information related to a sexually transmitted infection, sexual activity and/or orientation

❑ Other(s): please list _____

*HIV and Substance Abuse information is protected under federal law and must be authorized specifically in order to be use/disclosed.

This authorization will expire with the completion of treatment, unless otherwise changed and/or revoked.

I understand that I may revoke this consent at any time, and that I must notify Pediatrics at Newton Wellesley, P.C. in writing. I understand that such a revocation does not affect any action taken by Pediatrics at Newton Wellesley, P.C. prior to receiving my written notice.

_____ _____

Signature of Patient (or Parent/Guardian) Date

_____

Printed Name