Authorization to Exchange Healthcare Information

Dr. Jeffrey S. Feldman
Boston Children's
Primary Care Alliance

bostonchildrens.org/alliance/practices/jeffrey-s-feldman
781-662-4560 | *fax* 781-662-4585

Patient information

Patient name: _____

Date of birth: _____

Daytime phone: _____

Mobile phone: _____

Authorization

I understand that my medical and mental health information and records are protected by Federal and State confidentiality laws and regulations and cannot be released without my written consent unless otherwise provided for in those laws and regulations. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it.

I understand that my right to confidentiality under Federal law and regulations does not protect any information about a crime committed or suspected child abuse or neglect. In addition, if there is reason to suspect that I am in danger of physical, bodily harm, or that anyone else is in danger of physical, bodily harm, that information is not protected under Federal regulations.

I understand that information about HIV/AIDS, sexually transmitted disease, mental health, and drug or alcohol treatment can be released only if I sign the special consent below.

I hearby request and authorize the following exchange of information between:

Jeffrey S. Feldman, MD
340 Main Street, Suite 101
Melrose, MA 02176
781-662-4560 | Fax 781-662-4585

and

Name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone: _____

Relationship to patient: _____

I agree to allow my doctor, Dr. Jeffrey S. Feldman, to discuss my medical care with the person I have designated in order to coordinate my medical care.

I allow conversation/discussion about my general health care, however conversation/discussion relating to testing, diagnosis and treatment for specific areas is limited to the ones I have checked below:

❏ Mental Health/Psychiatric Disorders

❏ Drug, Alcohol Use/Abuse/Treatment

❏ Sexual Orientation/Sexual Activity

❏ Birth Control/Pregnancy

❏ HIV/AIDS Virus/Sexually Transmitted Diseases

Signature

Parent/Guardian name: _____

Parent/Guardian signature (or patient if 18 or older):

_____

Date: _____

Phone: _____

Email: _____