AFA OB/GYN P.C.
Emerson Hospital
John Cuming Building Suite 830
131 ORNAC
Concord, MA 01742
Ph: (978) 371-1396 Fax (978) 371-8277

There is a $25 fee payable at time this form is submitted. There will be an additional charge of $10 for records that need to be pulled from storage.

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____ Telephone No._____
Street City State Zip

I hereby authorize AFA OB/GYN to release protected health information, including copies of the medical record of the above named patient, to the following person or facility:

_____
Name of Person or Facility Telephone No. Fax No.

_____
Street City State Zip

Purpose of Release: ☐Medical Care ☐Legal ☐Insurance ☐Personal ☐Leaving AFA OB/GYN ☐Other: _____

**If leaving AFA OB/GYN please check reason(s):*
☐Insurance change ☐Moved/planning to move ☐Location/wanted some place closer
☐Dissatisfied with care/service received (please explain on reverse)

Information to be released

☐Office visits _____to _____ Specific clinician(s): _____
(Please specify a date range) *(Otherwise, all visits with all AFA OB/GYN clinicians during the period will be released)*

☐Lab Results _____to _____ ☐Radiology Reports _____to _____
(Please specify a date range) *(Please specify a date range)*

☐Complete Medical Record (Some items need specific consent – see below)

☐Other (please be specific): _____

Release of Information Requiring Specific Consent: The following categories of information may be included in your medical record and ***WILL NOT*** be released unless you indicate your specific authorization by **INITIALING** each appropriate category.

____ Abortion
____ Alcohol/Drug Abuse
____ Genetic Testing
____ Behavioral/Mental Health
____ Domestic Violence
____ Sexually Transmitted Diseases (this includes HPV status from PAP)
____ HIV/AIDS Results/Treatment
____ Rape/Sexual Assault

********Please confirm that you have INITIALED all categories of information that you would like released!********

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at AFA OB/GYN unless: (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to AFA OB/GYN at the address listed above. The revocation will be effective upon AFA OB/GYN's receipt of my written notice, except that it will not have any effect on any action already taken by AFA OB/GYN in reliance on this authorization.
- Once AFA OB/GYN has disclosed my health information to the recipient, AFA OB/GYN cannot guarantee that the recipient will not re-disclose my health information to a third party.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____
(Date of expiration)

_____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative Relationship to Patient Date

THIS AUTHORIZATION MUST BE COMPLETED IN ITS ENTIRETY OR IT WILL NOT BE PROCESSED!