



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

*******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!