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

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

Address: _____ Telephone No._____
Street City State Zip

I hereby authorize_____
(Provider/Office Name) (Address)

_____
(Phone No.) (Fax No.)

to release my protected health information, including copies of the medical record of the above named patient, to the following person or facility:

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

Information to be released

☐Office visits _____to _____ Specific clinician(s): _____
(Please specify a date range)

☐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!********

_____
Signature of Patient or Authorized Representative Date

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