AFA Obstetrics and Gynecology P.C.
John Cuming Building Suite 830
131 ORNAC
Concord, MA 01742

Phone: (978) 371-1396
Fax: (978) 371-8277

Patient's Name: _____ Date of Birth: _____

Address: _____ Telephone #: _____

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 # Fax #

_____
Full Address

Purpose of Release: ___Medical Care ___ Legal ___ Insurance ___ Personal ___Leaving AFA ___Other
*If leaving AFA, please check reason(s): ___Insurance change ___Moving ___Location/distance from home
___ Dissatisfied with care/service received (please explain on reverse)

Information to be released: Please specify dates/date range if applicable, otherwise ALL will be released.

____Office visits _____ to _____ Specific clinician(s): _____

____Lab Results _____ to _____ ____Radiology Reports _____ to _____

____ Complete Medical Record (*some items need specific consent, see below)

____ Other (please specify): _____

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 INITIALIZING each category, even if not applicable. Failure to do so may result in a delay in sending your record, should we have to redact.

____ Abortion ____Behavioral/Mental Health ____HIV/AIDS results/treatment

____Domestic Violence ____Rape/Sexual Assault ____Alcohol/Drug Abuse

____Genetic Testing ____Sexually Transmitted Diseases (includes HPV status from PAP)

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

_____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative Date

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: ____