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 _____
(Provider/Office Name)

_____
(Address) (Phone #) (Fax #)

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

AFA Obstetrics and Gynecology P.C.
John Cuming Building Suite 830
131 ORNAC
Concord, MA 01742
Phone: (978) 371-1396 Fax: (978) 371-8277

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

____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