AFA Obstetrics and Gynecology P.C.

John Cuming Building Suite 830 Phone: (978) 371-1396

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Concord, MA 01742

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

**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! \*\*\*\****

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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

**I understand that I may be charged a fee for the reproduction of the requested health information. This fee will**

**comply with Massachusetts Law Chapter 111: Section 70 with regard to the inspection and copying of medical records.**