AFA Obstetrics and Gynecology P.C.

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

131 ORNAC Fax: (978) 371-8277

Concord, MA 01742

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

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.