Concord OB/GYN

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Concord, MA 01742
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ DOB:_____ Telephone:_____

Address:_____

Concord OB/GYN Records Release Options
Option 1 - Release records to another physician's office (no fee)
Option 2 - Release of records to yourself or another recipient at your request (a fee will apply if the record is greater than 10 pages, otherwise no charge. Fee: $15.00 + $.50/page for the first 100 pages, and $.25/page after 100 pages)

I hereby authorize Concord OB/GYN to disclose to or obtain from the individual/organization named below the specified Protected Health Information.

Release records to:	**OR**	**Obtain records from:**
Name:		Name:
Street Address		Street Address:
City/State/ZIP:		City/State/ZIP:
Tel: Fax:		Tel : Fax:
Relationship to patient:		Relationship to patient:

For All Dates: (***Please initial***)_____ or Specific Treatment Date(s):_____

Please check information to be released

☐ Complete Record	☐ Pathology Report	☐ Operative Report	☐ Lab Reports
☐ Pap Smear Report	☐ Ultrasound Report	☐ MRI/CT Report	☐ Mammogram Report
☐ Office Notes	☐ Other:		

In compliance with Massachusetts Statutes which require specific authorization to release otherwise privileged information, by my initials and signature I specifically authorize the release of the following (please initial below if applicable, or write n/a if not applicable):

☐ Substance abuse (drug/alcohol) treatment
☐ Information related to sexually transmitted disease(s)
☐ Genetic testing
☐ Communications between me, my psychiatrist, psychologist, or other behavior mental health professional
☐ HIV/AIDS or ARC information
☐ Abortion consents/records or family planning services
☐ Sexual assault treatment
☐ Mammography records
☐ Information regarding treatment and diagnosis, if I am an emancipated minor (except to my parents)

FOR THE PURPOSE OF:
☐ Continuing Care ☐ 2nd Opinion ☐ Transfer ☐ Moving ☐ Personal Records ☐ Other_____

I hereby authorize said party to release my medical information as requested above. This may include information about drug or alcohol use, psychiatric, social work or other protected information unless otherwise excluded. I understand that the recipient that I have chosen to receive these records may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them. I understand that state and federal law protecting health information privacy may no longer protect the information furnished once it has been released.

This authorization will expire one year from the signature date. I understand that I can change my mind and revoke this authorization at any time in writing to the party releasing the records. However, the revocation will not have any effect on any action taken by the practice before it received my written notice of revocation.

I understand that I may refuse to sign this Authorization, and that such refusal or revocation will not affect the commencement, continuation, or quality of the practice's treatment of me; except, however, if my treatment at the practice is for the sole purpose of creating medical information for disclosure to the recipient identified in this Authorization. In that case, the practice may refuse to treat me if I do not sign this Authorization.

Date: _____ **Signature of Patient (if 18 years of age or older):**_____

Date: _____ **Signature of Parent or Legal Guardian**:_____