****

**AUTHORIZATION TO DISCLOSE or OBTAIN**

**PROTECTED HEALTH INFORMATION**

**MRN# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First Middle

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize and consent to the release of medical records obtained in the course of my treatment at

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the period of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and furnish records to **CircleHealth OB/GYN**

Address: **20 Research Place, Suite 320, N. Chelmsford, MA 01863**

Fax Number: **(978) 788-7343**

for the purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The specific information to be disclosed is:

\_\_\_\_\_\_\_\_ Progress notes \_\_\_\_\_\_\_\_ Hospital Records \_\_\_\_\_\_ Laboratory Reports \_\_\_\_\_\_\_ X-ray Reports

\_\_\_\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, assault, domestic violence, genetic testing, sexually transmitted disease, HIV texting, HIV results or AIDS information. \_\_\_\_\_\_\_\_\_\_\_ (initials)**

**I understand that:**

1. This consent is subject to revocation at any time except to the extent action has taken reliance thereon. This authorization will expire 90 days from the date shown below.
2. If I do not sign this form, my health care and payment for my health care will not be affected.
3. I may revoke my authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to my receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or a health care provider, the release information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that my records at ***CircleHealth OB/GYN*** are protected under federal regulations and that my information cannot be shared without my permission unless otherwise provided for in the regulations. Furthermore, I understand that if my records involve alcohol or drug abuse information, they are also protected under Federal Regulation 42 CFR part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
6. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
7. I can get a copy of this form after I sign it.

I hereby authorize ***CircleHealth OB/GYN*** to use or release the health information from the medical record of the person listed on the front side of this form. I have carefully read this form and agree to release the information specified.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Patient*  *Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Name*

If the patient is a minor or is otherwise unable to sign this Authorization, the signature of a parent, guardian or other representative is required.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Signature of Personal Representative Date*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Print Name Relationship of representative to patient*

**If the above signature is that of a patient’s representative, *CircleHealth OB/GYN*** **must complete the following:**

***CircleHealth OB/GYN*** has verified the identity of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Representative’s Name

By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and that in his/her capacity of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Means of Verfication (Driver’s License, Etc.) (Description of Authority – Husband, wife, etc.)*

He/she is authorized to act on behalf of the patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Employee Signature who verified identity Date*

**PLEASE COMPLETE ALL AREAS ON THIS FORM. IF ANY AREAS ARE LEFT BLANK, THIS FORM WILL BE RETURNED FOR COMPLETION. THANK YOU.**

**Return to:** Release of Information – Medical Records

CircleHealth OB/GYN

20 Research Place Suite 320

N. Chelmsford, MA 01863

Phone: (978) 942-2295 Fax: (978) 788-7890

Form: A-4, 10/30/19