Authorization to Release/Request Patient Information

Commonwealth OB-GYN One Brookline Place Suite 305 Brookline, Ma 02445

Phone: 617-732-1510 • Fax: 617-732-0986

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Name: _____ DOB: _____

Address: _____

City: _____ State:_____Zip: _____Phone:_____

I authorize Commonwealth OB-GYN to (please check appropriate response):

□ Receive Records From □ Send Records To

Name:_____

Address:_____City:_____State:_____Zip:_____

Phone: _____ Fax:_____

Please check the appropriate information to be released:

□ All records □ Visit notes □ Operative notes □ Lab results

□ Other (Please specify):_____

Are you transferring practices? □ Yes □ No

Signature:_____Date:_____

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Request for sensitive information: I understand that my medical records may contain information in reference to drug/and or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis testing/treatment. I agree to release this information.

Signature:_____Date:_____

Release of HIV information: In addition to the above signatures, if you want your HIV (AIDS) testing or treatment records released you must sign and date below.

Signature:_____Date:_____

If records are being released directly to you, please know there may be a record fee. If records are being sent directly to a physician, there is no charge. Feel free to contact the office at any time regarding records fees or the release form. Please allow 10 business days for records to be copied.