



About Women By Women, PC
Obstetrics · Gynecology · Infertility

30 Washington St, Wellesley, MA 02481
 111 Norfolk St, Walpole, MA 02081
 Tel: (781) 263-0033
 Fax: (781) 263-0098

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth: _____

Address: _____

Purpose of Release (check all that apply):

- Insurance / Disability Leaving AWBW Personal Going to a Specialist _____

Who has the records now?

Practice Name / Hospital Name / Physician's Name _____

Street Address _____

City, ST Zip _____

Phone _____ Fax _____

Where are the records going?

Practice / Hospital Name / Physician's Name _____

Street Address _____

City, ST Zip _____

Phone _____ Fax _____

Information to be released (check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Office notes | <input type="checkbox"/> Radiology reports | <input type="checkbox"/> Surgical reports |
| <input type="checkbox"/> Medication records | <input type="checkbox"/> Lab reports | <input type="checkbox"/> HIV test results |
| <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Other: _____ | | |

By signing this authorization, I understand that:

- ✓ As a result of this authorization, the health information disclosed may no longer be protected by the federal privacy standards and my health information may be re-disclosed by others without obtaining my authorization.
- ✓ I have the right to receive a copy of this authorization.
- ✓ I have the right to refuse to sign this authorization and that treatment, payment enrollment in a health plan or eligibility for healthcare benefits is not contingent on my signing this authorization.
- ✓ I have the right to revoke this authorization, except to the extent that the person(s) and/or organization(s) listed above have taken action in reference to this authorization.
- ✓ Once this authorization is completed and returned to our office, processing will normally take 5 to 10 business days.

Signature of Patient or Legal Representative _____

Date _____

About Women by Women • Medical Records

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(781) 263-9148

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Medical Records Production Fee: \$25.00