



## **Instructions for filling out the form:**

### **Obstetric Medical Record Release Form**

We will send this form to your obstetrician so that we may obtain medical records that are crucial to the success of the study.

- **Fill in your name, date of birth, and mailing address.**
- **Sign and date the form.**
- **Fill in your obstetrician's name, address, phone number, and fax number.**

\*\*\* After filling out the “**Obstetric Medical Record Release Form**”, you must also fill out the “**Authorization for Release of Protected or Privileged Health Information Form**” that follows (below).

**Both** forms must be returned to the Registry in order to be included in the study.

We greatly appreciate your time and effort in completing these forms and returning them to:

**AED Pregnancy Registry  
Massachusetts General Hospital  
121 Innerbelt Road, Room 220  
Somerville, MA 02143**

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) **1-888-233-2334**.



**MEDICAL RECORD RELEASE**

**TO WHOM IT MAY CONCERN:**

I hereby request release of all obstetrical records and information concerning \_\_\_\_\_ to:  
*(patient's name)*

Lewis B. Holmes, MD  
Director  
AED Pregnancy Registry  
121 Innerbelt Road, Room 220  
Somerville, MA 02143

**\*Patient's Date of Birth:**  
(MM/DD/YY)      \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Patient's Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_      **Today's Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Name of Obstetrician:** \_\_\_\_\_

**Obstetrician's Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Obstetrician's Telephone:** \_\_\_\_\_      **Obstetrician's Fax:** \_\_\_\_\_  
*(including area code)*      *(including area code)*



Antiepileptic Drug  
*Pregnancy  
Registry*

## **Instructions for filling out the form:**

### **Authorization for Disclosure of Medical Information From Another Facility** **(Adult version)**

This form complies with the Health Information Portability and Accountability Act (HIPAA). It is the national standard to protect the privacy of all health information, which is required by all hospitals and physicians' offices to have on file.

- **Please complete the information in the box at the top of page 1.**
- **Please fill in **your name** above “(Patient Name)”. Then fill in the name of either the physician or the health center where care is provided above “(Facility)”.**
- **On page 2, please initial for the release of genetic test results and psychotherapy in the second box, if you wish to authorize the release of this information.**
- **Sign and date at the bottom of page 2.**

We greatly appreciate your time and effort in completing these forms and returning them to:

**AED Pregnancy Registry  
Massachusetts General Hospital  
121 Innerbelt Road, Room 220  
Somerville, MA 02143**

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) **1-888-233-2334**.



**AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION**

- RELEASE COPIES OF HEALTH/MEDICAL RECORD
- REVIEW HEALTH/MEDICAL RECORD
- OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

<b>PATIENT NAME:</b> _____		<b>PATIENT DATE OF BIRTH:</b> _____	
<b>PATIENT MEDICAL RECORD #</b> _____ (IF ADDRESSOGRAPH STAMP IS NOT USED)			
<b>PATIENT ADDRESS:</b>	<b>STREET:</b> _____	<b>APT. #:</b> _____	
	<b>CITY:</b> _____	<b>STATE:</b> _____	<b>ZIP CODE:</b> _____
<b>TELEPHONE CONTACT #:</b>	<b>DAY:</b> (    ) _____	<b>EVENING:</b> (    ) _____	

I, \_\_\_\_\_ do hereby authorize \_\_\_\_\_ to release  
 \_\_\_\_\_ (Patient Name) \_\_\_\_\_ (Facility)  
 my protected health information including copies of my medical record of care received at \_\_\_\_\_  
 to the following persons at the locations/facilities listed below, for the purposes described:

	Person(s)/Facility/Address (include name and address)	Purpose (check the appropriate box)
1.	2.	<input type="checkbox"/> Medical Care <input type="checkbox"/> Insurance* <input type="checkbox"/> Legal Matter* <input type="checkbox"/> Personal* <input type="checkbox"/> School <input type="checkbox"/> Other (please specify)* _____ _____
_____	_____	
_____	_____	
_____	_____	
_____	_____	

\* Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. \*\* There may be additional charges for copies of photographs.

**INFORMATION TO BE RELEASED (Please check all that apply and specify dates):**

- |   |   |
|---|---|
| <input type="checkbox"/> Clinic visit notes _____   | <input type="checkbox"/> Photographs** _____          |
| <input type="checkbox"/> Discharge Summary _____  | <input type="checkbox"/> Radiation reports _____      |
| <input type="checkbox"/> Lab Reports _____  | <input type="checkbox"/> X-rays/Scan reports _____    |
| <input type="checkbox"/> Operative Reports _____  | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Pathology Reports _____  |   |
| <input type="checkbox"/> Medical Record Abstract (e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary) |   |

# AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

I request the release of the specific categories of information that I have *INITIALED* below:

- \_\_\_\_\_ **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)  
**SPECIFY DATES** \_\_\_\_\_
- \_\_\_\_\_ **Genetic test results** (excludes therapeutic genetic tests)  
**(SPECIFY TYPE OF TEST)** \_\_\_\_\_
- \_\_\_\_\_ **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2  
(FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)
- \_\_\_\_\_ **Other(s):** Please List \_\_\_\_\_

## Confidential Details of:

- \_\_\_\_\_ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
- \_\_\_\_\_ Social Work Counseling/Therapy
- \_\_\_\_\_ Domestic Violence Victims' Counseling
- \_\_\_\_\_ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire in 6 months unless otherwise specified:

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship of representative to patient:** \_\_\_\_\_

For Internal Use Only

Information Released/Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic/Office: \_\_\_\_\_