



Sharon S. Margulies, MD, FACOG
Sibel N. Bessim, MD, FACOG
Molly E. Clark, MD, FACOG
Georgia S. Vasilakis, MD, FACOG
Namita Kattal, MD, FACOG
Kara Deaver Chang, MD, FACOG

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 / Hospital Name _____

Street Address _____

City, ST Zip _____

Where are the records going?

Practice / Hospital Name _____

Street Address _____

City, ST Zip _____

Information to be released (check all that apply):

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

By signing this authorization, I understand that:

- ✓ Except in the case of insurance and disability claims, there is a \$15.00 administrative fee plus a charge of 35¢ per copied page of my records.
- ✓ 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.

Signature of Patient or Legal Representative

Date

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Tracey Marcalo, Medical Records Supervisor
(781) 263-9148

Medical Records Fax
(781) 263-9145