

Essex County OB/GYN Associates, Inc.
83 Herrick St. Suite 2004, Beverly, MA 01915
Phone:978-927-4800 Fax:978-232-5561

Provider Initials:
OK to Send:

Email: medicalrecords@ecobgyn.org | www.essexcountyobgyn.com

Patient Authorization to Release Protected Health Information

(Please note: We do not provide copies of records received from another physician or institution. Please request those records directly from the original health care provider.)

By signing this authorization, I authorize Essex County OB/GYN to use and/or disclose certain protected health information ("PHI") of a sensitive nature about me to, or for, the party or parties listed below.

This authorization permits Essex County OB/GYN to disclose to request from:

Name and Address

protected health information from the medical records of:

Last name

First name

MI

Date of Birth

Patient address

Patient Phone Number

I understand that the information in my medical record may include information relating to sexually transmitted disease, AIDS, and/or HIV. It may also include information about behavioral or mental services and/or alcohol and drug abuse treatment. I agree to its release: (initial YES or NO)

HIV/AIDS Yes No
Drug/Alcohol abuse Yes No
Psychiatric Yes No

Sexually Transmitted Disease Yes No
Social Service Yes No
Hepatitis B Yes No

This authorization will expire on _____ or one year from today's date, whichever comes first.

When my information is used and/or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Essex County OB/GYN has acted in reliance upon this authorization. My written revocation must be submitted to the COMPANY'S Privacy Officer at the business address.

Signature of Patient or Legal Guardian

Relationship to Patient, if applicable

Print Patient's Name

Date

Reason for request: moved dissatisfied transfer care change insurance consult

The fee for copying your chart is retrieval and delivery fee of \$25.00 (prior to 8/2006) and/or standard fee of \$10.00. (*Must be paid in advance of mailing) Check or Credit Card .

TOTAL COST: _____
*Please allow 2 weeks for delivery

Visa, MC, and Discover Accepted: Card Number _____

Exp Date: _____ Security Code _____