Essex County OB/GYN ASSOCIATES, INC
Caring for Generations

Beverly: ***Suite 2004*** and ***Suite 3002*** · 83 Herrick Street, Beverly, MA 01915
Gloucester: Addison Gilbert Hospital, 298 Washington Street, Gloucester, MA 01930
Danvers: 140 Commonwealth Ave. Suite 208, Danvers, MA 01923
Danvers: 480 Maple Street (3rd Floor), Danvers, MA 01923

Essex County OB/GYN Associates, Inc.
140 Commonwealth Ave., Suite 208, Danvers, MA 01923
Phone: 978-927-4800 Fax:978-777-4792

Faxed __Yes ___No
Date:_____
By:_____

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.

Reason for request: __Moved __Dissatisfied __Transfer Care __Change Insurance __Consult __PCP

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

_____
Name/Address/Telephone/Fax

protected health information from the medical records of:

_____ ____/____/____
Last name First name MI Date of Birth

_____ _____
Patient address Patient Phone Number

Specifically Requested Records:_____

By signing below I understand and specifically authorize the use and/or disclosure of the following types of highly confidential information relating to Sexually Transmitted Diseases (STD), AIDS, HIV, Genetic Testing, Hepatitis B, Rape/Sexual Abuse information, Behavioral and/or Mental Health information/services and/or Alcohol and Drug Abuse treatment/information.

_____ _____
Signature of Patient or Legal Guardian **Date**

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**

The standard fee for copying your chart is $25. This fee must be paid when this form is submitted. Include check or complete the credit card information below.

Circle type of card __ Visa __ Mastercard __ Discover (*Cardholder name and address must match patient name and address)*

Credit Card Number:_____ Exp Date:_____ Security Code:_____
