



Bedford Commons OB-GYN, PA
201 Riverway Place, Bedford, NH 03110
Phone #: 603-668-8400 Fax #: 603-625-1292
Authorization to Disclose Protected Health Information
Records Release of Information

Patient Name: _____ **Date of Birth:** _____ **Medical Record:** _____

Address: _____

I authorize Bedford Commons OB-GYN to:

Send/Disclose Information to: _____ **Receive Information from:** _____
 Name: _____ Phone #: _____
 Address: _____ Fax #: _____

For the following purpose(s):

Transfer of care Concurrent care Personal records Other: (Specify) _____

Type of information requested:

Consultation: _____ Ultrasound Reports _____ Progress Notes: _____ Mammogram: _____
Specify Specify Specify Specify
 Laboratory Reports _____ Operative Reports: _____ Pap smear: _____ Other: _____
Specify Specify Specify Specify

PCP Package: Most recent Pap, Mammogram, Annual Exam, Progress Note and Labs **Pregnancy Package:** ACOG Flowsheet, most recent Ultrasounds and Operative Notes

Dates of care to be released: _____ to: _____

I UNDERSTAND THAT:

- Bedford Commons OB-GYN will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- Once I authorize the disclosure of my health information, it is no longer considered protected information and re-disclosure by the recipient is legally permitted.
- I can revoke this authorization at any time by submitting a request in writing to Bedford Commons OB-GYN. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

▪ **The following types of information WILL BE INCLUDED UNLESS indicated by you initialing below:**

Drug and/or alcohol treatment: Initials: _____ **Psychiatric:** Initials: _____
Sexually transmitted disease: Initials: _____ **Genetic testing:** Initials: _____
HIV (AIDS) testing/treatment: Initials: _____

This authorization expires six months from the date of signature, or on: _____
 I have been offered a copy of this form.

 Signature of Patient or Legal Representative/Guardian Authority or Relationship of Representative Date
 (Attach copy of documentation of authority)

Must be completed by Bedford Commons OB-GYN staff:

Date received: _____ Date completed: _____
 Request completed by: _____ (Name)
 Delivery method: In Person Mail Fax Other: _____