



**Authorization to Disclose Protected Health Information**

Bedford Commons OBGYN - 201 Riverway Place, Bedford, NH 03110

Phone: (603) 668-8400 - Fax: (603) 626-7368

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Maiden Name or other name (if applicable) \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**I authorize Bedford Commons OB-GYN to (choose only ONE response) - Must complete all information.**

OR **Receive Records From:**  
**Send Records To:**

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please select the information to be released:**

1. Last GYN visit: Most recent Annual Exam, Office Notes, Pap test, Mammogram and Labs
2. Pregnancy Package: ACOG Flowsheet, Lab and genetic testing results (*initial "Sensitive information" box below*) Ultrasounds, Delivery Summary and Operative Report
3. Pap test only
4. Mammogram (Please specify where it was done): \_\_\_\_\_
5. Operative Report (Please specify type of procedure and date): \_\_\_\_\_
6. Other (Please specify): \_\_\_\_\_

**Are you transferring from our practice?**      Yes                      No

**Sensitive information:** I acknowledge, and hereby consent to such, that the released information may contain sexually transmitted disease (STD) testing, alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results, or AIDS information: \_\_\_\_\_ (initial)

**By signing this authorization, 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 pursuant to NH State Law Chapter 332-I section 332-I:1. There is no charge for record exchanges between healthcare providers currently treating you.
- 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.

\_\_\_\_\_  
Signature of Patient or Legal Representative/Guardian

\_\_\_\_\_  
Authority or Relationship of Representative  
(Attach copy of documentation of authority)

\_\_\_\_\_  
Date

\*This authorization expires six months from that date of signature or on \_\_\_\_\_. If you would like a copy of this form, please let us know.

BCOG Rep \_\_\_\_\_