AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Print patient's legal name: ___________________________________ Date of Birth: ___ /___ / ___

Address: ______________________________________________________________________________

*Street Address* *City* *State* *Zip Code*

Phone Number: _____________________________ please circle: home cell work

Alternate Phone number: _____________________________ please circle: home cell work

| **Please release my records from:** | **Please release my records to:** |
|---|---|
| Name of Obstetrician_______________________________<br>Clinic or Organization_______________________________<br>Address__________________________________________<br>City___________________ State _____ Zip Code _________<br>Phone__________________________________________<br>Fax____________________________________________ | Lee S. Cohen, M.D.<br>Principal Investigator<br>National Pregnancy Registry<br>185 Cambridge St.<br>Suite 2200<br>Boston, MA 02114<br><br>Phone: 866-961-2388<br>Fax: 617-643-3080 |

**Dates of treatment**: _________________ **Purpose:** Research

**I understand that:**

- All records will be released to the person clinic or organization named above including details of treatment for mental health, substance abuse history, genetic testing, communicable disease testing (including AIDS/HIV status). The information being requested includes: clinic visit notes, admission notes, discharge summary, record of labor, record of delivery, birth record, laboratory reports (mother & child), operative reports, x-ray/scan reports, consult notes, history and physical exam.
  If I **do not** want these to be released, I will initial here ______. I do not want the following records released:_________________
  ____________________________________________________________________________________________________.
- If I change my mind, I may write to my obstetrician's office to stop the release of my records. This will not apply to records that have already been released.
- This form expires one year after I sign it, unless otherwise specified: ___________________________________________.
- There may be a fee associated with the release of my records. Please direct any invoices to the Registry.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, health insurance, or participation in the research study will not be affected.
- Protected health information released to Lee S. Cohen, M.D. is protected by Partner's HealthCare and the Health Insurance Portability and Accountability Act (HIPAA).
- I have carefully read this form and do herein expressly and voluntarily authorize disclosure of the above information from my medical record to the person listed above for the purpose listed above.

___ /___ / ___ ______________________________ ____________________________

**DATE** **SIGNATURE OF PATIENT** **PRINT PATIENT'S NAME**