

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Print mother's legal name: _____ Mother's Date of Birth: ___/___/___

Print baby's legal name: _____ Baby's 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:

<p>Name of Hospital where patient delivered _____</p> <p>Address _____</p> <p>City _____ State _____ Zip Code _____</p> <p>Phone _____</p> <p>Fax _____</p>	<p>Lee S. Cohen, M.D. Principal Investigator National Pregnancy Registry 185 Cambridge St. Suite 2200 Boston, MA 02114</p> <p>Phone: 866-961-2388 Fax: 617-643-3080 Email: registry@partners.org</p>
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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 the hospital listed above 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.
- Information disclosed pursuant to this authorization may be redisclosed by the recipient and no longer protected by federal health information privacy laws.
- 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