

Authorization to Release/Request Patient Information

Commonwealth OB-GYN
One Brookline Place Suite 305
Brookline, Massachusetts 02445
Phone: 617-732-1510 • Fax: 617-732-0986

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Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

I authorize Commonwealth OB-GYN to (please check appropriate response):

Receive Records From

Send Records To

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Please check the appropriate information to be released:

All records Visit notes Operative notes Lab results

Other (Please specify): _____

Are you transferring practices? Yes No

Signature: _____ Date: _____

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Request for sensitive information: I understand that my medical records may contain information in reference to drug/and or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis testing/treatment. I agree to release this information.

Signature: _____ Date: _____

Release of HIV information: In addition to the above signatures, if you want your HIV (AIDS) testing or treatment records released you must sign and date below.

Signature: _____ Date: _____

If records are being released directly to you, please know there may be a record fee. If records are being sent directly to a physician, there is no charge. Feel free to contact the office at any time regarding records fees or the release form. Please allow 10 business days for records to be copied.