New England OB/GYN Associates, Inc.
Authorization to Release/Request Patient Information

Patient Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____

NEOGA Physician _____

I authorize New England OB/GYN Associates, Inc. to disclose and deliver information from my medical record to: _____ via mail _____ via fax

Name or facility _____ Attn _____

Address _____ City _____

State _____ Zip _____ Phone _____

Fax number if information to be faxed _____

Please check the appropriate information to be released:

___ All records** ___ Visit notes/ patient history ___ Operative notes/discharge summaries
___ Lab/test results-specify type/date _____
___ Consult note-specify date _____ ___Other _____

I understand that treatment and coverage is not based upon my signing this authorization.

- I understand that this authorization is subject to revocation at any time unless action based on it has already begun. This authorization expires in six months from the date of signature.
- I understand that the information may be subject to re-disclosure and may no longer be protected by federal or state law.
- I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release is done substantially in accordance with applicable law.

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

If the following sensitive information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

HIV Testing and Results □ Yes □ No Dates: _____
STD Results (other than HIV) □ Yes □ No Dates: _____
Genetic Testing □ Yes □ No Dates: _____
Mental Health (other than psychotherapy notes) □ Yes □ No Dates: _____
Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____

□ I DO □ I DO NOT agree that a copy of this form is valid as the original.

⇒ **SIGNATURE** _____ Date _____

⇒ _____
Witness or parent/guardian signature if applicable Date

Comments:

Normal processing time is 7-10 business days. 7-2018