WINCHESTER OB-GYN ASSOCIATES, P.C.

1021 Main Street – Suite 102
Winchester, MA 01890
Ph: (781) 721-4701
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Home#: _____ Cell#: _____

☐ I authorize Winchester OB/Gyn to **RELEASE information to:**

OR

_____ Name of Provider / Facility	_____
_____ Address	_____
_____ City, State, Zip Code	_____
_____ Phone # Fax #	_____

PLEASE NOTE: *Normal processing time to produce medical records is **10 business days**. As a courtesy, we will copy and mail records to another physician or medical center free of charge. A fee of .25 cents per page will be charged for all other*

PURPOSE FOR THIS REQUEST: _____

TYPE OF RECORDS REQUESTED: (check one)

☐ All medical records; or

☐ I only want parts of my medical record, described below, to be disclosed:

_____

_____

AUTHORIZATION FOR RELEASE OF SENSITIVE OR STATUTORILY PROTECTED INFORMATION FROM THE MEDICAL RECORD

The following categories will ***NOT*** be released from your medical record unless you indicate your authorization by initialing next to the corresponding category or categories: **Please initial all for complete medical release**.

_____Alcohol Abuse	_____Sexual Abuse	_____Rape
_____STD Testing	_____Substance Abuse	_____Sexual Assault
_____Genetic Testing	_____HIV Testing	_____Mental Health

_____ _____

Signature of Patient (or Legal Representative) **Date**