BAYSTATE OB/GYN GROUP, INC.

PATIENT AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION 1: Records recipient

By signing this authorization, I authorize Baystate Ob/Gyn Group, Inc. ("BOGG") to use and/or disclose certain protected health information (PHI) about me to:

RECIPIENT'S NAME: _____

RECIPIENT'S MAILING ADDRESS: _____

_____

RECIPIENT'S FAX NUMBER:_____

SECTION 2: Records to be released

This authorization permits BOGG to use and/or disclose the following individually identifiable health information about me (please select one of the two options):

☐ Please provide ENTIRE medical record.

☐ Please provide a copy of the specific information as outlined below:

_____ Date of treatment_____

_____ Date of treatment_____

SECTION 3: Expiration

This authorization will expire on _____

SECTION 4: Authorization

I do not have to sign this authorization in order to receive treatment from BOGG. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Baystate Ob/Gyn Group, Inc., 3455 Main St, Springfield, MA 01107

Patient name (please print) _____

DOB _____ Today's Date: _____

Signed by _____ Relationship to Patient: _____

(Signature of Patient or Legal Guardian)

SECTION 5: Special Releases

DO NOT SKIP

The following category of records we may have on file for you requires specific authorization for release. It is important that you select **YES** or **NO** and **INITIAL** each item listed below. Please do not skip any line as it could impact our ability to fulfil your request and cause additional delays.

HIV/AIDS: I hereby authorize release of protected healthcare information pertaining to HIV testing and/or diagnosis and/or treatment of Acquired Immune Deficiency Syndrome (AIDS) solely to the person or organization described above.	**YES or NO** ☐ ☐	**INITIAL:** _____
SEXUALLY TRANSMITTED DISEASE RECORDS	**YES or NO** ☐ ☐	**INITIAL:** _____
GENETICS: I hereby authorize release of protected healthcare information pertaining to genetic test results to the person or organization described above.	**YES or NO** ☐ ☐	**INITIAL:** _____

SECTION 6: Optional

*(Completion of section 6 is **not a requirement but** we do appreciate your feedback.)*

Are you ending your care with Baystate Ob/Gyn Group, Inc. (BOGG)?

☐ No, I am not ending my care with BOGG

☐ Yes, I am ending my care with BOGG on _____

Reason: _____

Would you like to be contacted to discuss further?_____