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

Patient Name _____ DOB _____

Address _____ City _____

State _____ Zip _____ Phone _____

NEOGA Physician _____

I authorize the following facility:

Name of facility _____

Address _____

State _____ Zip _____ Phone _____

To release the indicated medical record information to:

New England OB/GYN Associates, Inc.

200 Boylston St, Suite 301

Chestnut Hill, MA 02467

Fax 617-566-2224 _____ via mail _____ via fax

Date of treatment _____

☐ All records ☐ Specific information _____

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

→ **SIGNATURE** _____ Date _____

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Witness or parent/guardian signature if applicable Date

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Request for Sensitive Information – I understand that if my medical record contains information in reference to drug and/or alcohol abuse, psychiatric, venereal disease, social service, Hepatitis testing/treatment, and/or sensitive information I agree to its release.

→ **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 _____