Antiepileptic Drug
Pregnancy
Registry

# Instructions for filling out the form:

## Neurological Medical Record Release Form

We will send this form to your neurologist so that we may obtain medical records that are crucial to the success of the study.

- **Fill in your name, date of birth, and your mailing address.**
- **Sign and date the form.**
- **Fill in your neurologist's name, address, phone number, and fax number.**

*** After filling out the **"Neurological Medical Record Release Form"**, you must also fill out the **"Authorization for Release of Protected or Privileged Health Information Form"** that follows (below).

***Both*** forms must be returned to the Registry in order to be included in the study.

We greatly appreciate your time and effort in completing these forms and returning them to:

**The North American AED Pregnancy Registry**
**Massachusetts General Hospital**
**125 Nashua Street, Ste 8438**
**Boston, MA 02114**

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) **1-888-233-2334**. **Please have healthcare provider fax records to 617-643-0071.**

MASSACHUSETTS GENERAL HOSPITAL

MassGeneral Hospital *for* Children

HARVARD MEDICAL SCHOOL

# MEDICAL RECORD RELEASE

**TO WHOM IT MAY CONCERN:**

I hereby request release of all neurological records and information concerning _____ to:
*(patient's name)*

Lewis B. Holmes, MD
Director
AED Pregnancy Registry
125 Nashua Street, Suite 8438
Boston, MA 02114

***Patient's Date of Birth:**
(MM/DD/YY) ___ ___ / ___ ___ / ___ ___

**Patient's Address:** _____

_____

_____

**Patient's Signature:** _____ **Today's Date:** ___ ___ / ___ ___ / ___ ___

**Name of Neurologist:** _____

**Neurologist's Address:** _____

_____

_____

**Neurologist's Telephone:** _____ **Neurologist's Fax:** _____
*(including area code)* *(including area code)*

Antiepileptic Drug
Pregnancy
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# Instructions for filling out the form:

## Authorization for Disclosure of Medical Information From Another Facility

(Adult version)

This form complies with the Health Information Portability and Accountability Act (HIPAA). It is the national standard to protect the privacy of all health information, which is required by all hospitals and physicians' offices to have on file.

- **Please complete the information in the box at the top of page 1.**
- **Please fill in your name above "(Patient Name)". Then fill in the name of either the physician or the health center where care is provided above "(Facility)".**
- **On page 2, please initial for the release of genetic test results and psychotherapy in the second box, if you wish to authorize the release of this information.**
- **Sign and date at the bottom of page 2.**

We greatly appreciate your time and effort in completing these forms and returning them to:

**The North American AED Pregnancy Registry**
**Massachusetts General Hospital**
**125 Nashua Street, Ste 8438**
**Boston, MA 02114**

If you have any questions while filling out this form, or need help, please call the AED Pregnancy Registry (TOLL FREE) **1-888-233-2334. Please have healthcare provder fax records to 617-643-0071.**

PARTNERS™

# AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION

___ RELEASE COPIES OF HEALTH/MEDICAL RECORD
___ REVIEW HEALTH/MEDICAL RECORD
X OBTAIN COPIES OF HEALTH/MEDICAL RECORD FROM ANOTHER FACILITY

**PATIENT NAME:** _____ **PATIENT DATE OF BIRTH:** _____

**PATIENT MEDICAL RECORD #** _____ (IF ADDRESSOGRAPH STAMP IS NOT USED)

**PATIENT ADDRESS:** **STREET:** _____ **APT. #:** _____

**CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

**TELEPHONE CONTACT #:** **DAY:** (  ) _____ **EVENING:** (  ) _____

I, _____ (Patient Name) do hereby authorize _____ (Facility) to release my protected health information including copies of my medical record of care received at _____ (Facility/Doctor) to the following persons at the locations/facilities listed below, for the purposes described:

| Person(s)/Facility/Address (include name and address) | | Purpose (check the appropriate box) |
|---|---|---|
| 1. **LEWIS B. HOLMES, M.D.** | 2. | ☐ Medical Care |
| **AED PREGNANCY REGISTRY** | | ☐ Insurance* |
| **125 NASHUA STREET, STE 8438** | | ☐ Legal Matter* |
| **BOSTON, MA 02114** | | ☐ Personal* |
| | | ☐ School |
| | | ☒ Other (please specify)* RESEARCH |

* ***Please refer to the Partners HealthCare Privacy Notice for information on copying fees that may be associated with this request. ** There may be additional charges for copies of photographs.***

## INFORMATION TO BE RELEASED *(Please check all that apply and specify dates):*

☒ Clinic visit notes _____
☒ Discharge Summary _____
☒ Lab Reports _____
☒ Operative Reports _____
☐ Pathology Reports _____
☐ Photographs** _____
☐ Radiation reports _____
☒ X-rays/Scan reports _____
☐ Other *(please specify)* _____

☒ Medical Record Abstract *(e.g. History & Physical, Operative Report, Consults, Test Reports, Discharge Summary)*

_____

_____

_____

**See Page 2 on Reverse**

# AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION

**I request the release of the specific categories of information that I have *INITIALED* below:**

N/A **HIV test results** (PATIENT AUTHORIZATION REQUIRED FOR EACH RELEASE REQUEST.)
**SPECIFY DATES** _____

_____ **Genetic test results** (excludes therapeutic genetic tests)
**(SPECIFY TYPE OF TEST)** _____

N/A **Alcohol and Drug Abuse Records** Protected by Federal Confidentiality Rules 42 CFR Part 2 (FEDERAL RULES PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED OR WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2.)

_____ **Other(s):** Please List _____

**Confidential Details of:**

_____ Psychotherapy (from a Psychiatrist, Psychologist, or Mental Health Clinical Nurse Specialist)
_____ Social Work Counseling/Therapy
_____ Domestic Violence Victims' Counseling
_____ Sexual Assault Counseling

I understand that:

- I may withdraw my authorization at any time by submitting a written request to the Director of Health Information Management, or the Office Manager in my Doctor's Office. Authorization may be withdrawn except for the following:
  - to the extent that action has been taken in reliance on this authorization.
  - if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by Partners HealthCare.
- I understand that this authorization will automatically expire in 6 months unless otherwise specified:

_____

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

**Patient's Signature:** _____ **Date:** _____

**Print Name:** _____
When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

**Signature of Legal Representative:** _____ **Date:** _____

**Print Name:** _____ **Relationship of representative to patient:** _____

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____

Clinic/Office: _____